

STATE PLAN FEEDBACK 2002

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In reviewing the waiver on the website, I have one comment on the respite care. I believe that since the definition is to give the primary care giver a short duration break from their duties, that a provider be allowed to perform sibling care for young children while caring for the client. It makes no sense whatsoever that a parent should hire a 2nd person to watch a younger sibling and have a qualified individual care for the client for a short (6 hours?!) break. Now understand that I am not advocating a free ride, but allow a provider to charge a reasonable rate for this service if they want to provide this. I believe this would be beneficial to many parents who have young children. Thank You for your consideration	L
Families need REAL INPUT by having representatives from Raleigh get in their cars and drive to local family support meetings in Western North Carolina. INPUT NEEDS TO BE VALUED. Most families have given up. Any State Plan needs to include 24/7 crisis care that is REAL. So call "hot lines" that tell you to take your child to the hospital is not community based services. Families need 24/7 crisis intervention and stabilization as an alternative to hospitalization.	H
I only want for my brother the standard of living and quality of life he grew up with rather than inferior housing and uneducated staff. For a family member to visit him in the places where he has lived and see no one he can relate to is disheartening. Thank you for your interest and on-going to improve the lives of persons with mh/dd/sa.	
Rest homes were designed and staffed for fragile, dependent, elderly persons, not for healthy bodied young or middle aged adults. It must be made clear in the State Plan that adults with a mental illness who don't need hospitalization but need supervision (some treatment) will have fair, adequate, and appropriate housing and services. We are not addressing the Olmstead issues in our state by merely making adult care homes available as the "community" setting of choice for people discharged from our state psychiatric hospitals. It is not yet truly clear to me how we are going to better serve the mentally ill consumers by them merely residing in the community. However, I appreciate that this is the stated intention.	
ACT teams are absolutely necessary for those with a chronic (severe) life long, mental illness and are needed right now because one of the most common symptoms causing regression and return to a hospital environment is not taking prescribed medicine. ACT teams can prevent crisis and monitor individuals closely. Just as the developmentally disabled have services provided in their homes and successfully stay out of the institution, so must all others. I have visited others who have a developmental disability and live in HUD homes where the conditions are vastly more home-like and therapeutic and this makes me angry. I long for equality for my loved one.	

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I write as a family member very sad today about this problem. I wonder if in fact my brother, my parents, or if I will ever see him get a chance that does not set him up for failure. Statistics show that each time a person with schizophrenia is re-admitted to the hospital, he or she regresses quicker because of their own perceived failure. At the same time, I am very grateful for and believe in the good of the hospitals. My brother and only sibling, two years older, was placed in a rest home last year and he liked it because of a "less restrictive environment" after hospitalization for almost a decade this last time. I was happy for him but saw ahead that he would fail due to lack of supervision. Gradually, the staff let him do what he wanted to keep the bed filled. He got sicker and sicker and is now back where he came from.	M
Does the state really understand the needs of the severely mentally ill? Unfortunately the most knowledgeable, insightful staff work inside the institutions, not in the community and very few are in top administrative levels of state government where all of these decisions are being made. Get families of the mentally ill if you can find any left who are involved and get chronic people themselves to help the team see the real picture. There may not be time for the Plan to help my brother now that he is middle aged. He should have had such opportunities when younger. But it will and must help those very young who will face a very hard life and those who are born in the future. Mental illness has always been around and will never go away. Even with tremendous medical/psychiatric progress, some individuals who are born with this brain disease and their families will suffer until the end of time. No one knows unless they have been there.	
Seems to me a major roadblock in providing a consistent home/community based system of care for children and/or their families is transportation(more specifically, the lack thereof).	M
Transportation appointments need to be organized, supervised and taken seriously by clients then waiting during appointments, to returning the clients to their place in the community.(home, school, daycare, etc.)	
Year after year I see well educated, skilled professionals spending many hours each week collecting children and/or parents from home, school etc. and then transporting them to evaluations, medical appointments, therapy counseling and such. Responsible adults with reliable vehicles are needed to provide transportation under the coordination of a central supervisor for the use of such a service in the most efficient, cost effective manner possible.	
We are concerned that many individuals with severe challenges will still not receive needed services unless there is increased funding. (9)	H
We need to assure a team approach to services that is committed to involving the consumer and the family and all the service providers in a coordinated way. The way services are funded doesn't really support this team approach. (7)	M
There are opportunities for more private providers to provide services in our communities, and we need more providers to give individuals more choice. (7)	H
Area Programs need to put a lot of attention into developing a provider network. There are already many providers for some services (e.g. CAP-MR/DD funded services) and more will emerge. (6)	H
Neuse Center and the private providers need to work in partnership for the benefit of the consumers. (5)	H

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There is a need for special transitional services to support those people who will be leaving the institutions and moving into the community. (3)	H
We want a more flexible, individualized expense account for services that is based on needs of the individual. (4)	L
We want a more efficient use of services and better-managed resources. We should look at outcome-based services. (3)	L
We need to focus more on supported employment so individuals can be more financially secure and therefore more independent. (3)	M
In view of funding constraints, we should be working with families to assist them in supporting their family members. (3)	L
We want more family involvement and responsibility in the provision of services, wherever possible. (2)	L
We, as a community, need to work on this together -- volunteer groups, private providers, area program, church groups -- to build a more caring community that is sensitive to consumer needs. It's called "community mental health" for a reason. (1)	M
DDA group homes may no longer be managed by Neuse Center. From the residents' perspective, these are their homes and not some service. This could disrupt a long-term relationship that is at the core of the residents' feelings of security and belonging.	H
There needs to be a wider variety of services that is more consistent with the desires of the consumers, e.g., more opportunities for recreation and leisure activities that facilitate community integration. (1)	L
We need to put more emphasis on employment services to promote real independence.	L
Let people live their own lives by supporting their choices, but not controlling them.	L
Any changes in the services system need to respect the therapeutic relationship that currently exists between consumers and their present provider (e.g. the Area Program). (9)	H
Will programs like Milestone Day Treatment (for At Risk Children) continue to be able to operate?	H
Current funding (CAP/MR-DD) does not distribute money out equitably. Aggregate waiver funding, instead of "slot funding," would spread the money out more equitably and serve more people. (8)	H
Legislators and policy makers need to spend a day in the community talking with consumers (outside the beltway). (5)	
The system needs to be more sensitive to what the consumers and families want. The families need to have more say.	
It doesn't appear that there has been much real consumer involvement in the development of the State Plan.	
A consumer suggested that the state cars that are put on auction (about once a year) could be used to help consumers with transportation.	

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The state needs to understand our commitment to consumers being people, citizens, and understand services and their funding being an investment in our greatest natural resource, people. (2)	
There are strong concerns about people who will be coming out of state institutions and back to their communities of origin. Where will they live and where will the money come from to support them through community-based supports? How will the state fund those necessary services, especially after it has already raided the mental health trust fund? (8)	H
Small counties like Jones will be seriously hurt due to a lack of funding and a weak tax base. The state keeps adding mandates that cost the counties more than they can afford. The state government is busting the small counties. North Carolina is one of the few states that require a local match for Medicaid, and now they are taking state dollars away from the counties at the same time they shift the cost of mental health onto the counties. "They are killing us dead. They're destroying Jones County, and now they're trying to destroy Neuse Center." (8)	H
There is strong concern about the number of private providers who exist to serve consumers, or who can be attracted to a small rural county. For substance abuse and mental illness, there are almost no private providers. (3)	H
Will I have to leave my house? Will I lose my home (will I lose my current provider, the Area Program)? (2)	H
There is concern that the length of stay at places like Cherry Hospital will be decreased and people will return to the community before they are sufficiently stable. (1) (MH)	H
Will there be a sliding scale for service provision?	L
Is there any funding being directed to the prison system, which will likely be receiving an increase in population due to cuts from the state for community mental health services? (MH & SA)	L
Problems with the concept of building a private provider network in small rural counties like Pamlico: First, within a 30-mile radius, there are no private providers of mental health services and almost no providers of substance abuse services. Development of a private provider network simply isn't realistic; in the last five and a half years there have been no RFP respondents to provide bids for local services except for the Area Program. And, there is no transportation, nor any money for transportation to services outside the county. (13)	H
Moving from thirty-nine area programs to twenty local management entities while privatizing services, including the individual case management that has historically assured person-centered services, will lead to an uncoordinated disarray of services! (10)	L
Make sure that Clubhouse services (psychosocial rehabilitation) are listed as part of the "array of services" for persons with severe and persistent mental illness. (5) (MH)	M

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<p>Please accept my thanks to you and your staff for the incredible work that you've done in preparing the "State Plan" for MH/DD/SAS. The document, and even importantly the process that has occurred in preparing it, represents a serious commitment on behalf of you the Department and the State to improving the public mental health, development disability and substance abuse services delivery system in North Carolina. I want to reiterate the incredible importance of mental health and substance abuse services for persons living with HIV/AIDS. We recognize that upwards of 75% of those living with HIV/AIDS also have some mental health and/or substances abuse problems, and that treating the HIV disease without also appropriately addressing the mental health/substance abuse issues has little chance of long-term success. We continue to hear concerns from HIV service providers about the difficulty that clients have accessing public mental health/substance abuse services in the current environment.</p>	
<p>Our county government leaders haven't seen fit to even publicize that there are changes coming for the system, let alone to ask for public input.</p>	
<p>The plan needs to be strengthened to support the function of local Client Rights Committees, or whatever group will replace them, so that they can indeed operate with integrity to their purpose. Although I am certain that this is not true in all communities, there are Area Programs whose CR Committees exist in name only, having no power to bring about much needed change and little influence on how decisions are made. My</p>	
<p>I am writing to express my concern with the proposed State Plan and its impact specifically on the autism/developmental disabilities community. It was brought to my attention that the new waiver plan will allow for the addition of music therapy and art therapy services, but excludes the provision of recreation therapy. To familiarize myself with information related to the waiver, I read through the files included on the CAP-MR/DD web page and within the State Plan 2001: Blueprint for Change.</p>	
<p>In the DD Supports and Comprehensive Waivers- Issues and Questions (March 25, 2002 Waiver Advisory Committee Meeting), I came across a statement about the addition of art and music therapies with the reasoning that these services have been requested in the past and currently have HCPCS codes. The document continues to say that there are not yet codes for other creative therapies, although it does not specify whether recreation therapy is considered part of that group. Because the State Plan (p. 24- Work, School, Activity, Leisure) acknowledges the importance of health and wellness, meaningful relationships, and activities outside of work and education (areas that are addressed by recreation therapy), my assumption is that recreation therapy has been excluded due to the lack of a HCPCS code.</p>	

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In the Waiver Services Menu and Definitions Worksheet, art and music therapies were not listed as individual services, or under an existing service, so I am not certain how they are coded. This information would be useful in helping me understand the decision regarding recreation therapy. While I do not argue the value of music and art therapy services, I feel strongly that it is a disservice to this population (particularly those with autism) to deny recreation therapy services. Activities encompassed in recreation therapy promote areas such as social interaction, decision-making skills, health and wellness, and independence, which are typically areas for growth and development among people with autism. A large component of recreation therapy is also community integration, which has been identified as a key part of the NC DHHS Mission: "North Carolina will provide people with, or at risk of...developmental disabilities...and their families the necessary...services and supports that they need to live successfully in communities of their choice."	L
Please take this into consideration in upcoming discussions about the State Plan. If I have been misinformed in any way or am interpreting the information incorrectly, please correct me and provide accurate information so I can understand the decisions that are being made.	
We appreciate your interest in public mental health issues in our state. For a long time mental health has suffered due to oversight in the scheme of things.	M
However, it has come to our attention that the plan as it is now would cause problems for current recipients. We would like to take a brief moment of your valuable time and mention some of these concerns.	
The primary concern we have is the lack of definition for a "valid outcome". From our standpoint a valid outcome is time away from the hospitals and begin a member of society.	
Under the current plan that a valid outcome could be seen as "number of persons served". This would be returning us to a "revolving door" with institutions and in the end would save no money.	
Surely, you can see that services that keep people out of the institutions are an economical and viable alternative, rather than waiting for a recipient to become ill to receive services.	
Enclosed you will find information of a very valid program that could be lost under the current state plan guidelines. Please consider learning more about psychosocial rehabilitation programs and the services they provide before they are lost under the new state plan.	H
There is special concern about psychiatric services. Small rural counties have never been able to attract psychiatrists. Without the Area Program, there would be almost no psychiatric services for people with serious mental illnesses. (8)	H
The few private providers that exist in our community are not experienced in treating people with severe and persistent mental illness, and for the most part, don't want to serve them. (6)	H
The funding cuts that Area Programs have already endured have resulted in the loss of valued staff, which results in a net loss of services. (11)	H
What will happen to early intervention? It sounds as though all the funding will go to a half of a pound of cure! (3)	L

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Services for consumers are ultimately going to cost more, not less, because the plan is so short sighted. (2)	H
We are concerned about the quality of care for individuals who are severely behaviorally challenged and in need of clinical supports, given that private providers typically do not do therapy with persons who are cognitively challenged. (2)	H
We don't need to exclude Area Programs from being providers in order to expand choice.	H
We need to use volunteers to supplement services. Need to establish a referral list both of private providers that provide services and volunteers who can provide supports.	L
We are outraged over services that have already been lost due to insufficient funds for mental health services, outraged that the State Plan will result in even further cuts, and fearful about how these cuts will impact the many people whose needs will go unmet. (26)	H
It is less costly to provide outpatient individual therapy than to pay for hospitalization. We need to put more money into outpatient therapy as a cost-effective early intervention. It will save money on hospitalizations. (21)	H
The problem is money, not the system. The system is already under-funded, which has resulted in problems that will only be compounded when the State Plan restricts funding further by serving only target populations. People are not getting individual therapy they need and they now have to be served in group sessions. If they won't accept being served in groups, then they have to go to private providers, which are almost nonexistent. The groups are too large and non-specific to be effective. (16)	H
Private providers who will serve people with severe mental illness and/or substance abuse problem are simply not available in small mostly rural counties like Carteret. (14)	H
Who will be responsible for protecting the rights of persons served, and how will it be done? (This references a perceived right to receive service)	
We need an ombudsman to help protect the rights of people, especially those who will have to go unserved. (3)	
There is major concern about people who live in Group Homes, Therapeutic Homes or with Alternative Family Living providers that are operated by the Area Program. If Area Programs have to divest themselves of these services, will these people lose their homes, their friends and surrogate families, and their continuity of care? We are talking about people's homes and the therapeutic relationships that have been built up over many years of caring support. "If they close down Spencer Place (group home for people with severe and persistent mental illness) where will we go?" (31)	H

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A number of people go to Neuse Center to see the doctor (psychiatrist) for medications. How will that change? Without the Area Program, there would be no doctor available for some people for medications, but the State Plan doesn't consider this a core service! What happens to those people who don't have money for seeing a private psychiatrist or who can't get in to see one because there aren't enough in the community? "Should I start looking for a new doctor today so I can be one of the few who gets in with a private psychiatrist?" There is a shortage of psychiatrists everywhere. Neuse Center is now charged with making referrals, which will increase the business for local private providers, but where are the providers? (20)	H
Where is the incentive for private providers to get into the business of serving people with severe and persistent mental illness? Medicaid pays for some services, but the reimbursement rates are not sufficient for costs like psychiatric/medication services. And there is NO incentive to serve people who cannot pay. To understand this problem, look at dental care. There are no local dentists who will take any additional patients with Medicaid. People on Medicaid have no local (within 30 miles) options, and so they go unserved, even though there are lots of dentists. (16)	
There is much concern about people in crisis who need to be seen immediately to avoid needing hospitalization. Under the State Plan, crisis intervention is a core service, but what about emergency medication and emergency treatment/stabilization that go beyond the immediate crisis interventions. Without the appropriate stabilization services, the person may very quickly lapse back into crisis. (10)	M
If the State is going to decrease the number of psychiatric hospital beds, where will people go in crisis? Will the money saved on those beds go to the community to keep people out of the hospital? All of it? (9)	H
This public forum shows the need for increased community support and for us to work together to find solutions among ourselves like our Tri-county Mental Health Support Group. However, how will we continue to create local support groups if Neuse Center becomes only a Local Management Entity? They facilitated the development of our support group as an extension of the treatment they provided. Private providers won't have any incentive to, and will not help consumers to develop their own groups. (9)	H
How can private providers who have no experience with serving people with severe and persistent mental illness qualify to provide services? It doesn't make sense to put the people who have the experience out of business just to turn that business over to people who do not have the experience. (7)	H
Therefore, bridge funding will continue to be an issue with the current status of no new dollars, the reality of community-based services may be difficult to achieve. The services that span the continuum of care are absolutely necessary to ethically and competently serve clients. There must be access to residential services, inpatient stabilization services, partial hospitalization/day treatment services and outpatient services. Attempting to provide mental health services in the community is best practice. However, it will be harmful to consumers if services are not adequate and funding is not available to provide efficient and effective services.	H

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There is much concern among the members of River Club (psychosocial rehabilitation program) about the future of their Clubhouse program. Psychosocial rehabilitation has been a core service, but it is no longer a core service under the State Plan. Will it be recognized as part of the array of services that will be funded for people with severe and persistent mental illness? Enduring therapeutic relationships are central to the success of the Clubhouse model. Will the area program be forced to divest this program, and if so, who will run it? "I want it to stay open. It helps me better myself, and without it, I wouldn't be employed." (4)	M
Promote client-centered practices by providing treatment in the most therapeutic and least restrictive environment. Pursuant to the Olmstead decision, we believe that consumers should receive care in the least restrictive and most beneficial environment.	H
In addition, practitioners may be forced to take on administrative tasks and consequently limit the time they have actual consumer contact. Many of the administrative duties (e.g., Medicaid billing, reimbursement and obtaining services for clients through Value Options) associated with changes in the provision of local mental health services may fall on the practitioners and not on the LME's. Overhead will increase for existing agencies and will be higher than the current market allows for those that are being formed. Again community based services are most appropriate but for the Plan to be truly realized, the financial support must be in place. As a result of the shift in the provision of mental health services at the community level, the provider has increased responsibility to assure that the consumer receives appropriate and necessary services. There is the potential for increased liability for the provider should the consumer not receive these services.	H
Medications are very expensive. Who will help me with this? (3)	L
The schools refer children who are threatening to harm themselves or others. Will this service be able to continue, and will the Area program be able to do more than just assessment? (2)	H
Neuse Center has already had to decrease some services due to reductions in funding that resulted in frozen positions. This has resulted in increased utilization of therapy groups, and this is a problem for people in or near crisis who have difficulty with group therapy. Some people are dropping out of treatment altogether because they are too uncomfortable to work in groups, and because private alternatives are not available or affordable. (2)	H
Area programs retain approximately 5000 staff across the state. These transition issues will serve as barriers to successful implementation of the state Plan without careful, thoughtful deliberation by DHHS and the General Assembly.	L
In addition, we support greater clarification and analysis in the design and transition of the clinical delivery system in terms of best clinical practice, outcomes, quality clinical care and model programs.	M
Much of the system reform effort has been focused on governance, funding, and leadership. Psychiatry in North Carolina demands that quality clinical care be a focus as well.	

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In particular, the process by which existing effective public sector clinical teams transition seamlessly to provider network status needs to be spelled out in much greater detail. Failure to do so threatens both the continuity of client care and the trust of	
We believe that the role of the psychiatrist needs to be clarified. We specifically recommend that there be defined roles for psychiatric physicians in the system leadership structure at each level: DMH/DD/SAS/LME, and Clinical provider unit.	
Finally, the we would also like to reiterate our on-going concern that quality community mental health services and supports be in place BEFORE the state hospitals or institutions are downsized, merged, or closed.	
You asked for comments. I did e-mail the senators and representatives via e-mail on behalf of our local Advisory Mental Health Board in Polk County. Your plan calls for direct services to be offered by private providers. As a small rural county there are not enough private providers to fill the need. Transportation by the clients to Hendersonville or Asheville would be impossible and providing transportation would be costly. We have an excellent working relationship between DSS workers, mental health workers and Guardians. We can discuss clients needs and provide the best services on a cooperative basis. By offering referrals only, this would destroy that relationship. By joining with other counties into a large catchment area we are afraid we will lose the personal touch and caring that mental health workers are able to provide--to see the whole picture and the whole family--not just a phone call and referral. The proposed elimination of state hospital beds down the road will mean a return of patients to rural counties which do not have the resources to deal with emotionally unstable clients.	H
Polk County will be at the mercy of the larger catchment area in terms of services and input. We are attempting to assess the needs of our Polk County residents and design programs to meet these needs in a cooperative venture with other agencies. We are afraid we will be swallowed up when we combine with several other counties. The new plan may save money but will it meet the mental health needs of our residents?	
They will also increase, rather than decrease, the waiting time for services in most cases. I am concerned that no serious effort has been made to obtain input directly from the consumers themselves. I am concerned that this plan will benefit private providers, many of who, currently rely on paraprofessionals (e.g. CBI and HRI technicians.) for the delivery of many services, without improving the quality of care available to those who need it most.	H
In attempts to assure continuity of care to some of my clients who were moving out of state, I have had contact with the mental health program of at least one other state(Florida) that operates under a system similar to that proposed by this plan in an effort to arrange an initial appointment. It was dreadful!!! And I was unable to secure an appointment for my client. The intention of empowering mental health clients and consumers by providing them with a choice of providers is commendable.	
However, the plan does not provide a mechanism for doing this effectively. Nor, would I respectfully submit, should such a change be created by eviscerating public mental health services as the current plan would do.	

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We would like to strongly encourage physician and other clinical participation as this process continues and the details are forged in redesigning the delivery system for our patients and the unserved in our state. We look forward to working with you in the process.	
We appreciate the opportunity to be involved in the process of mental health reform. We applaud and support the efforts of the Legislative Oversight Committee, the Secretary of DHHS, and the Division of MH/DD/SA toward the goal of moving patients from our institutions to the community. We do, however, continue to have concerns in the following areas. Community Capacity: We are very concerned about all that must be done to develop a best practice clinical delivery system that will substantially reduce the need for acute and longer term state-operated facility services for children and adults (including meeting the needs of specialized populations such as geriatric, deaf and hard of hearing, etc.). How will the Division assure that adequate, appropriate, and accessible community-based services are implemented before the safety net is dismantled, as has been promised?	H
We frankly question the true capacity of private provider networks, particularly in more rural areas, relative to the degree, quality, and types of services that the plan rightfully envisions as necessary to meet the needs of the target populations. It is unlikely that there will be a sufficient pool of competent providers statewide to serve our current public mental health clients. There are very few circumstances in the current plan where public services can be provided by the LMEs. We recommend changes in the State Plan to allow for more flexibility in the provision of services. Several models exist that could be useful. Currently, for example, there are community services being offered by the state to group homes for the developmentally disabled via institutional staff to assure quality community services. The development of private/public partnerships may also be needed. Further, strengthening ties with the university system may provide expertise to assure quality services and sound methods for assessing outcomes.	
Additionally there will need to be some statewide specialty services (e.g. for deaf persons). It would not be cost effective for all LMEs to offer these services. It is not clear where these services will be located or how they will be managed outside the state facilities.	H
Assuring Access to Quality Care Before moving any patients from our institutions, quality community services should be in place. Psychologists have advanced training and expertise to make a major contribution in this regard. We would like to know what the Division is currently doing to ensure that best practice services are in place prior to further closing of hospital beds. Our interest would include knowing the Division's criteria for assessing successful implementation of community services (that would then lead to informed decisions to reduce hospital beds) and the specific quality improvement processes that are being used. Who is responsible, when, and where? Psychologists could play a key role in the QI process, and would welcome the opportunity to do so. The LOCUS/CALOCUS is being used to evaluate the services each hospitalized patient will need to be placed in the community. At this point, many of these services are unavailable.	H

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<p>To focus in more depth on one population, there is already an effort on the part of the Division to move a large proportion of ICF level geropsychiatric patients out of the hospitals by June 30, 2002. These patients are highly compromised, having both mental and physical illnesses. They frequently exhibit behavioral symptoms that make their care a challenge. The only bridge money designated for these patients is \$20,000 for minor renovations at the Wilson Care Center and \$100,000 for Real Choice Case Information and Assistance. The only placements available are Wilson Care Center and local nursing homes. Although less expensive, moving patients to Wilson Care Center is not a real community placement, but rather is a move from one institution to another. Also, unless the patients are from that community, they will be farther from family members and supports than they were when hospitalized, creating logistical and emotional hardships. Local nursing and rest homes have numerous problems that make them a poor choice for the care of our patients.</p>	H
<p>These include staffing shortages, high staff turnover, poor training in the care of persons with mental illness, and insufficient therapeutic treatment interventions designed for persons with psychiatric problems. There is also far less oversight in these facilities relative to rights issues, as compared to state-operated facilities. Specialized group homes and foster care have been successfully tried in other states should be considered as viable alternatives to nursing or rest home placement. Nursing and rest home staff need to be trained and given ongoing supervision in behavioral and psychosocial treatments if they are going to care for persons with such problems.</p>	M
<p>Similar detailed considerations must be taken into account relative to all the targeted disability populations. For example, there are children and adults with developmental disabilities and extreme behavioral disorders, whose needs have not been met in the community. These individuals require intense, behavioral treatment involving highly trained staff and professional consultation. Such services need to be in place in the community before discharging from the institutions. People can be placed in the community, but the services and supports they receive may not be as adequate as those provided in the institutions. Paradoxically, there may be some cases wherein community care is not less restrictive. In addition, there are some clients that the community will not accept.</p>	M
<p>Funding: Our primary current fiscal concern is the inadequacy of bridge funding in the context of the current state budget crisis. The \$12,002,264 in the Trust Fund is a very small amount of money to implement the anticipated minimally necessary array of services for the target populations prior to the timetables established for downsizing the state-operated facilities. There is also concern due to the great disparity in wealth among the counties across North Carolina. In a period of recession, the state seems to be asking the counties to increase their budgets for mental health services. We support the emphasis in the reform bill on greater local accountability. However, in the current environment, this may be a burden the poorer counties are not going to be able to manage. The state will need to be able to make accurate estimates of the state dollars required to supplement these county budgets.</p>	H

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Cost estimates and cost impact studies have not yet been conducted. These can't be done until there are comprehensive definitions of the services that are to be offered. Both will be essential in order for local communities to develop their business plans. We suggest a delay in the deadline for these plans until cost estimates are available.	H
NCPA supports a primary emphasis on community-based programming. What we are advocating is that planning for the transition to the new paradigm satisfactorily address a realistic appraisal of fiscal needs, problems associated with establishing an adequate provider network, and the challenge of fulfilling the commitment to enhance community capacity prior to substantially downsizing capacity in state-operated facilities.	
What is meant by "evidenced-based?" What really works best for Substance Abuse? What do the studies / research say works for SA? (1)	L
What will happen to people who leave hospitals (inpatient treatment)? What will there be in the community for them? This is in reference to the decrease of hospital beds that will be available under the new state plan. (1)	H
Is there a "best practice" system of treatment for identified substance abusers? (1)	L
How do we engage substance abusers in treatment? Where do they come from into treatment? How do we get substance abusers to realize that they need treatment and to follow through? How do we motivate them to participate and stay clean? (1)	L
We are concerned that Substance Abuse is a major community problem that has not been addressed adequately. SA affects the justice system, the public health system and the social services system – all costing the community money.	M
We are concerned that the cost of Substance Abuse treatment is so high because the target population is already heavily involved with their addiction. It seems that early intervention would be less costly and more appropriate.	M
What early intervention will be provided?	M
How will hospitals address the increased/growing population? An increase in inpatient hospitalizations is expected due to less early intervention.	H
Where will Detox occur? Where will individuals get Detox?	L
Substance Abuse is a family issue. What will be done to address it as such?	L
Mental Health services "overshadow" Substance Abuse services. Substance Abuse services are currently under-budgeted, and the needs of people with substance abuse problems are "swept under the carpet." When is funding specifically for Substance Abuse going to be delineated? This is a request for separate funding for SA services much like there are funds specifically targeted for Developmental Disability services. (3)	L
We need qualified/effective Substance Abuse providers for effective treatment, but Substance Abuse providers are paid less than mental health clinicians. (2)	L
We are concerned about the unknown extent of substance abuse (alcohol) among the elderly: This is not being addressed by medical doctors, even though there is a biological component. SA seems to be more prominent than realized in the elderly community. These individuals are not known to the system and primary physicians fail to inquire/investigate about alcohol abuse.(2)	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
Array of Services	
There is a critical shortage of private providers in our highly rural area. Just where are these private providers going to come from?	H
We need more intensive case management positions for people who have multiple needs, especially those related to accessing services (transportation).	L
The problem of substance abuse in our communities is enormous. Every family is likely to experience substance abuse in some way.	M
Even where there are Substance Abuse providers, there is a shortage of culturally sensitive substance abuse services.	H
Substance abuse still carries a serious social stigma, and that stigma carries over into a lack of support for Substance Abuse services.	L
There are no residential supports except Host Homes, and Host Home providers are not in it for the money.	L
Regarding the need to assist family members of persons with mental illness, developmental disabilities, substance abuse issues -- we often think about the parents or spouses as being the family members who need assistance. It is in my opinion even more urgent to assure that the needs of the children of adults with mi/dd/sa receive support services. If an adult is diagnosed as having mi/dd/sa, this should serve as a flag to find out whether there are children who are affected by the adult's illness. Whether or not the adult with mi/dd/sa is in the home or is out of the home, in a psychiatric hospital for example, there needs to be an assessment to answer such questions as: --what is the status of the child(ren) of the parent /caretaker? -- who is taking care of the child(ren) and is this good for the child(ren)? --has someone explained to the children about what is going on, where the parent is, etc.? --what support does the child need at this time? --are the child's teachers aware that the child may need support during this time? --etc.	L
Children of persons with mi/dd/sa should be a target, or priority, population for the redesign of the our MH/DD/SA system.	L
Recently I attended a NAMI NC conference and a consumer told me that recently her ACT Team (or maybe just a member of the ACT Team) recognized that she (consumer) was not doing as well -- was decompensating. The consumer said that she herself had not realized that she was decompensating. I told her I would pass her comment along. It appears from her example that an ACT Team's contact with a consumer can help prevent hospitalization and crisis because of early intervention. Want to make the point that the ACT Team was able to recognize that the consumer was not doing well even though the consumer did not realize it herself.	
consumers in a meeting were asked what helps keep consumers out of the hospital ? answers were: clubhouses; peer support groups; medication; therapists and psychiatrists; adequate housing; community support; hotline run by consumers with a psychiatrist there; ACT team	H
How can your services be "consumer-driven" and "built on consumers' strengths" if you do not have adequate consumer input? Or it is listened to with seriousness and intent to use it?	H

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
Array of Services	
<p>I think more programs are needed, there are so many mentally handicapped just sitting at home day in and day out. Something needs to be done about this! With all the very large companies here in Wilmington alone why aren't they donating funds to their community? Where I'm from up north most of our fund raising is from them. They get their money back from Uncle Sam or is it programs just haven't asked? I have noticed that things get done when someone in office has a member in their family. Who can I air problem with. I have a son (24) with Downs Syndrome who has been on a waiting list. Soon to be a year and there is nothing available for him. It breaks my HEART to see him mope around all day. No friends no nothing. And they say there's a god in HEAVEN!</p>	H
<p>The people of NC have been promised that "MH/DD/SA clients will not be moved from State facilities until adequate services are in place in the community" but this is a false promise. In order to keep with the "time schedule" of the State Plan facilities are being closed before new services are ready (ex: Trend, Community Hospital Health Care, the new MH facility in Chatham County, etc.)- SEC. HOOKER ODOM STATED THAT THE BOTTOM LINE IS: CARE OF THE CLIENT! I don't see that happening. Money is being pulled from our state facilities to build community services even before LME's are organized. What is to happen to "The Client" while services are being built in communities? How many fragile and dependent clients will be forced into less than adequate community facilities just so NC's Dept. of HHS can boast of accomplishing the "reform" within five years. Why not take 10 years or more to protect vulnerable clients and create a system worthy of the expense and effort.</p>	H
<p>No one who cares about disabled persons would deny them opportunities to enjoy the best services possible, but the Olmstead Decision stressed the states' responsibility to provide CHOICE whether in community or ICF/MR facilities. Where is CHOICE when state facilities are being downsized or closed and clients are being sent to Adult Care Homes or Special Care Facilities, without a choice for the client or his/her family. There is no CHOICE, often only the weak fact that "the client did not object". Maybe the client was not capable of objecting?</p>	
<p>Experience in other States proves that closing State Institutions too quickly, or at all, can bring some tragic results for clients. Statistics just now being reported also show that providing same services for "like" or clients of similar disabilities is no less expensive in the community than the State facilities. The costs can even be higher in community facilities. MY SUGGESTION IS MAKE THIS REFORM VERY SLOWLY AND WITHOUT DESTROYING THE QUALITY SERVICES OUR STATE NOW HAS. KEEP STATE FACILITIES STRONG AND LET THESE AND COMMUNITY SERVICES EXIST TOGETHER FOR THE GOOD OF ALL CLIENTS. BEST PRACTICES CAN OCCUR IN BOTH SETTINGS AS CAN SELF ADVOCACY. N.C. DOES NOT NEED TO COMPETE WITH OR DUPLICATE OTHER STATES IN OUR MH/DD/SAS SYSTEM. N.C. CAN BUILD A SYSTEM WHICH MEETS THE NEEDS OF N.C. CITIZENS! DON'T MAKE THIS A POLITICAL GAME!</p>	H

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
Array of Services	
<p>We hope that the implementation of the proposed Plan will make a significant and positive difference in assuring that these individuals will find a more accessible and responsive delivery system tomorrow. We are pleased that the Plan specifically designates living with HIV/AIDS among the "priority populations" to be served by mental health and "target populations" to be by substance abuse providers this is an important beginning. We are concerned, however, that the proposed business plans and implementation activities of the to-be-developed Local Management Surely, for the individual clients' health status and the protection of the public's health, there can be no greater need. We are prepared to help you implement the Plan and these priorities in any what we can.</p>	
<p>You asked for comments. I did e-mail the senators and representatives via e-mail on behalf of our local Advisory Mental Health Board in Polk County. Your plan calls for direct services to be offered by private providers. As a small rural county there are not enough private providers to fill the need. Transportation by the clients to Hendersonville or Asheville would be impossible and providing transportation would be costly. We have an excellent working relationship between DSS workers, mental health workers and Guardians. We can discuss clients needs and provide the best services on a cooperative basis. By offering referrals only, this would destroy that relationship. By joining with other counties into a large catchment area we are afraid we will lose the personal touch and caring that mental health workers are able to provide—to see the whole picture and the whole family—not just a phone call and referral. The proposed elimination of state hospital beds down the road will mean a return of patients to rural counties which do not have the resources to deal with emotionally unstable clients.</p>	M
<p>Polk County will be at the mercy of the larger catchment area in terms of services and input. We are attempting to assess the needs of our Polk County residents and design programs to meet these needs in a cooperative venture with other agencies. We are afraid we will be swallowed up when we combine with several other counties. The new plan may save money but will it meet the mental health needs of our residents?</p>	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
TARGET POPULATIONS	
We are very concerned that current recipients of services may no longer qualify for funding, and therefore may lose their services. (10)	H
We are very concerned about those people who are currently not getting the services they need, who will continue to decompensate until they become eligible for crisis services. (8)	H
We need much more clarity on who will be eligible for services and how eligibility determinations will be made. Right now there is a lack of clarity that creates much anxiety for families and consumers alike. (5)	H
There are a lot of people who are not Medicaid eligible who would be able to live relatively independently in the community if provided with supports, but who will not be able to receive those supports because they do not meet the narrowly defined eligibility criteria of the target population. (12)	H
Prevention and Early Intervention: If we don't serve the people who are currently not the most challenged, eventually those individuals will become severely in need. (3)	H
Given the target populations defined in the current State Plan, it appears that many people may have to become seriously ill, even lapse into crisis, before they can be served. (27)	H
Concerns about people who are not within the target groups and who can't afford to pay for services: "I can afford to pay for my own services now, because Neuse Center kept me alive when I couldn't afford to pay!" "This is not going to work. People will fall between the cracks." "We are literally going to lose people." "People's lives will be destroyed." (12)	H
There is serious concern about families who are seeking care for the first time. Who will assure that they receive the family-oriented care and early intervention they need to cope with the complexities of severe and persistent mental illness? (7)	H
Target populations: (pg. 14 and the disability specific plans) The State Plan does not set clear criteria for when an individual is a member of the target group. In addition the target populations identified in the plan are so large that it will not assist the LME in managing limited resources. Suggested change: This section needs to have clear criteria and more clearly defined definitions of target populations for all disability areas. Level of care guidelines must be developed along with a clear set of services and service guidelines to establish target populations and priorities within the target populations. (We are) willing to work with the Division to develop Statewide criteria and defined target populations that could be used by the LME to manage limited resources.	
There is major concern about those people who fall outside of the narrow target populations and whose services will therefore not be funded. This concern is based on the likelihood that the cost of serving these people is being shifted onto the local county governments that lack the resources to meet their needs. (14)	H
If we have narrowly defined target populations, like IV drug users with HIV/AIDS, what will happen to funding for prevention, and what will happen to people who have serious drug problems but are not IV Drug Users, not diagnosed with HIV/AIDS, or otherwise fit in the narrowly defined target population?	L
There is serious concern about the people who do not fit into the target populations and who do not have Medicaid, private insurance or the ability to pay. These people will fall through the cracks. People won't get served until they go into crisis! (7)	H

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
TARGET POPULATIONS	
1)."Target Population" are definitely an issue, appropriately calling for a lawsuit. 2). There is a need to define the criteria of a reversion, what is meant by decompensation?	H

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
I didn't see anything relating to law enforcement and the legal system involved with people who have mental illness. When a mental patient is confronted by law enforcement either as a public nuisance, disruptive behavior or by criminal action there are no statewide guidelines on procedure. Too often that person will spend considerable time in jail before receiving professional help: assuming that their condition is even recognized at all. Also, the court system from magistrates up to the Supreme Court need to be advised about mental illness and programs to help. A mentally ill person should not be jailed but referred to a crisis center or hospitalized. Punitive action will not rehabilitate a sick person nor will it impress upon them any need to "get well" and not repeat any antisocial behaviors.	L
I want to request that you consider separating Developmental Disabilities from Mental Health and Substance Abuse. The needs of the developmentally disabled are quite different and require separate types of treatment and assistance which are quite specialized. In addition, I hope that one day the CAP waiver have a separate category for the extraordinary life-long needs of folks with autism.	L
I would like to make a proposal regarding the current Plan's directives with respect to the Psychiatric Rehab Unit at John Umstead Hospital. The Rehab Unit is unique in this state in terms of the quality of "extended-stay" inpatient treatment provided--both national and intersystem consultants have praised the clinical services afforded there to SPMI adults needing targeted treatment interventions within a highly structured and safe environment. Recent site visits from the Department of Justice, as well as last year's JCAHO accreditation audits, note the value of the programming provided. Recent research facilitated in part by one of our physicians, Michael Golding, MD, provides outcome data which indicates that our rate of success (measured by the patient remaining out of the hospital at least one year out) is amongst the highest in the nation.	L
NAMI family members, Area Program providers, and even Division on staff continue to speak highly of our program and lament, along with us, the proposed down-sizing which would likely result in irreparable damage to the Rehab Program through the loss of extremely qualified clinicians, program specialists and nursing/ward staff. My proposal is this: since the eventual plan is for JUH to merge with Dix Hospital (regardless of the eventual geographical location), the new facility would already be set up to offer state-wide "specialized" services (i.e., the Forensic Unit, the Deaf Unit). I propose that the current JUH Rehab Unit be part of that plan in that it would remain a viable part of the NC continuum of services provided to SPMI adults, both in the Central Region and--potentially--statewide. UNC, Duke, etc. If you believe this proposal has merit, it is vital that the program be protected in terms of the current schedule of downsizing beds and staffing. I would be happy to provide any further information to help clarify the Rehab Unit's current mission and potential. Thank you in advance for your attention to this proposal	L
By providing an inpatient service that could not cost-effectively be duplicated in a community-based, managed care system, the Rehab Unit could be unique in its scope by offering a targeted menu of treatment services to patients as well as providing for an appropriate setting for continuing research in conjunction with UNC, Duke, etc. If you believe this proposal has merit, it is vital that the program be protected in terms of the current schedule of downsizing beds and staffing. I would be happy to provide any further information to help clarify the Rehab Unit's current mission and potential. Thank you in advance for your attention to this proposal	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
If the State is as poor as it reports; budgets are to be cut further in 2003; the Federal Government probably will not increase Medicaid funding to N.C.; and demands for services are still growing, then how can the success of the State Plan be expected? Where is the funding to come from? Will solutions be more of the same, that is, take budgeted money from each State facility to meet emergency demands in one of the sections? This has been going on for years and has not corrected the problems of MH/DD/SA services.	L
Page 1 - There are too many important discrepancies between this plan and House Bill 381: An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level. Before this process goes much further, these documents need to be brought into alignment or neither one will be effectively implemented, if they can be implemented at all with the current discrepancies running rampant through them.	L
Consumers and families who participate in quality management and service monitoring activities should have avenues to report their findings to someone at the State level as well as to the LMEs. They should also publicize their results widely through many different types of media outlets and, perhaps, conferences/town meetings. Once again, these people should NOT be chosen by the LMEs or county commissioners but through a public call for volunteers as with CFACs. I would really NOT choose BRAA as a pilot project. There are too many power mongers on the Board and the county commissioners are in their pockets. Their disrespect and disregard for the consumers and family members whom they are supposed to be serving is legendary. I have heard good things about Foothills Area MHDDSAS, though.	L
One-stop settings? BRAA is refusing to do mental health and substance abuse services under this new system. BRAA is the only major provider of those services in this entire area. There are only a handful of psychiatrists and maybe twice as many therapists of any type who will take Medicaid around here. Thus, not giving written approval of the DHHS Secretary for BRAA to continue to provide mental health and substance abuse services would be tantamount to refusing services to like 90% of Medicaid clients in this area. However, if BRAA succeeds in its plan to subvert the system by creating a new private, nonprofit entity to provide those services, we have the old fox in the chicken coop problem again. They simply cannot be permitted to oversee themselves--conflict of interest AND they already ignore all their consumer and family member councils, committees and subcommittees. It's even worse for the rural communities as the current system utterly fails at providing services in the rural communities themselves--let alone proper oversight.	L
Thus, it would seem that transportation is key to getting people to where they can access services.	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
BRAA is already in direct disregard to the development of their local business plan as an LME because they have neither publicized this plan nor called for public input by consumers, family members and advocates about the plan they've devised, let alone put together these committees prior to making their plan. Having a staff member choose the members of the local advisory committee will just make a bad situation worse by allowing them to "stack" the LACs with brown-nosers who seem to think that their family members will receive better treatment if they agree with everything the director says, thinks and does. I think that is a REALLY bad arrangement. Guess it'll be awfully difficult for the State committee to review OUR local committee's report since we don't have one... The current council, committees and subcommittees would like to be able to fulfil your requirements as to their responsibilities but are unable to get the information and access necessary to do so.	L
With regard to the implementation of the state plan for reform in the delivery of mental health services, what mechanism is in place to ensure meaningful citizen review? I am specifically referring to the difference between token involvement of persons selected by the current regime and substantive involvement of advocates who are routinely closed out of the decision-making process. What mechanism will ensure that decision-making involves individuals and groups beyond the current regime and their token appointees? I am concerned about those Area Directors whose intent is to conduct business as usual, in which case the LME will be simply a continuation of the current board and administrative structure, just named something else. My fear is that nothing will change in Guilford County. The County Commissioners will look to the current area director to tell them what to do. She will happily oblige, develop her own version of a local plan with a very small, hand-picked advisory committee, and continue business as usual.	L
My question is where are the teeth in the process to keep the charade from continuing. If the local plan is not submitted according to the prescribed criteria, what is the consequence? If a local plan is submitted but not approved, what is the consequence? If the citizen review process is short-circuited by a less than honest approach to the selection of appointees to the citizen review committee, where are the teeth in the plan?	L
Who developed the state plan?	L
How do we get the message across to our legislators about the problems we see in this plan and about the needs of the people in the community? (6)	L
Persons with SPMI are among the very most needy in terms of Medicaid eligibility. The cost of the necessary antipsychotic medications prohibits many persons with mental illness from getting adequate care. It is time for North Carolina to overhaul its Medicaid system to ensure that people with SPMI are eligible for Medicaid. Those who are ineligible because of their SSDI check are falling through the cracks. The SSDI check cannot possibly cover the costs of antipsychotic meds. And the calculated spend-down is at a level that is mathematically impossible. The formula for calculating the spend-down for these folks needs to be changed so that eligibility criteria can be met. For my brother, that is impossible.	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
I really think (and it was also the consensus of the consumer working group on our conference call) that the Consumer and Family Advisory Committees should be able to report, not only to the LMEs, but directly to the State as well since many problems are closely tied to, if not caused by, the LMEs themselves. Also, these CFACs should not be appointed by the LMEs or county commissioners as that is a conflict of interest. There should be widespread public calls for volunteers for the CFACs and the members should be chosen by all the consumers and family members who answer that call (should there be too many who answer the call for the committees). These committees should also be given all information necessary to do their jobs in an effective and timely fashion (which is not the case currently with these committees and councils at BRAA). Clear protocols for whom to contact at the State level should be available to these committees AND all consumers and family members who request them.	L
I would like to endorse the position paper that the North Carolina Mental Health Consumer Organization has sent to the Mental Health Project Team as a list of my own personal concerns regarding the new state plan.	L
Why are there so many unknowns in the State Plan? It suggests that they (the State) don't really know what they are doing, which is scary because the devil is in the details that have yet to be explained. (7)	L
There is serious ethical concern about the way that Mental Health care is being compromised by purely financial considerations. (4)	L
How can we attract/develop Substance Abuse providers in our (rural) area? Transportation is a problem and there are no providers in outlying areas. We need satellite offices. Consumers are sometimes unable or unwilling to travel the distance to the outpatient center in Morehead City even if they do have transportation. Many do not have transportation and Carteret County Area Transportation System is insufficient. (2)	L
Gentlemen: Of later there have been articles in <u>The News and Observer</u> relative to plans to improve mental health services in North Carolina. When those new articles began, I became hopeful that our badly broken mental health plan would be improved; however, to my dismay early on ideas suggested closing institutions and placing more patients in their communities.	L
It is very difficult to view this as an improvement when our communities are already filled with many men and women of all ages who clearly have psychiatric problems. In communities such as Havelock, there are no psychiatric professionals and we do have several mentally ill patients who receive little or no help until the commit a crime. Then there is an outcry for a short time until the shock wears off and we go back to doing nothing. In one case, a young man actually murdered two people before he was committed to Dorothea Dix.	L
In our family we have a 45-year-old son who is mentally ill. He receives approximately 7 minutes of time with a mental health professional about every 3 to 4 months. At this last visit, he saw a new person to whom our son described his depression, despair and anguish only to be told, "Well, David, I don't know what to tell you. "In the city of New Bern in Craven County (which is where our son is considered a patient), there exists a fine written mission statement and there are numerous programs described in various documents. It is nothing more that a paper program.	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
Our son desperately needs better care than that. We often read of marvelous advances being made in the mental health field but those advances have not reached the average mental health patient in the community.	L
The reality of the treatment actually given bears little or no relationship to their written programs. My husband and I are 80 and 78 years of age respectively. As long as we are alive and reasonably able, we will give our son David, a home. Yes, he is sometimes difficult often depressed and angry and often not cooperative. After our demise, God only knows what will happen to David. He is a prime candidate to become a homeless street person making one bad choice after another until he lands in jail. My husband and I are very distressed by this prospect but have no idea ho to improve his situation.	L
If there is any hope at all of making this "Community" project work, the quality and number of participating professional must be greatly improved. How can this be done? These professionals must be highly qualified highly respected by their peers and the community; unfortunately for our budget, highly paid. Small towns have little or no chance of acquiring such people.	L
Your data showing numbers of employees employed at Dorothea Dix and Butner were a surprise to me. I have not visited either facility, but I have visited Cherry Hospital.	L
While visiting Cherry, it was obvious that many of the employees are unskilled and untrained in any medical discipline. They quality of education of these people must be improved. With highly qualified people in communities or institutions, the expense is surely high. Where do we get the money? Initially we must take a budgetary hit; however, in the longer term we will save considerable money by having a saner population, fewer crimes, fewer arrests and fewer prisons.	L
Yes, this is difficult to sell, but we must offer higher quality mental health services to our citizens. Are there many people in governments who will take up this cause? Probably not. It is surely an unrewarding crusade but one which can no longer be ignored.	L
By having the criteria for a three-year transition the MH/DD/SAS has unnecessarily caused great consternation and stress among consumers, their families and friends, who are concerned about services, and among Mental Health System employees who are concerned about their jobs and being able to properly assist consumers. This at a time when budget restrictions had already caused great concern. This is the opposite of what the charge of the Department is. In my opinion the Department needs to change the plan to eliminate the three-year requirement and allow greater flexibility for LME's to provide services. It needs to immediately start a comprehensive public relations program both at the State and Area Authority levels aimed at addressing peoples concerns and thereby hopefully lessening their contribution to the stress.	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
The State Plan also requires that everyone work together to build a new and better system. It requires county government leaders to engage all of their citizens in discussion and decision-making about governance and local business plans. Not only is this not being done in some areas, but also there seems to be an attempt to hide what is being done. The plan does not need to be changed in this area; it just needs to be adhered to. Forums that do not cost \$25 need to be held so that all citizens have an opportunity to hear those who are provide a challenge to providers and the public in the Western Part of the state.	L
Just for the record, both my wife and I very, very concerned about the proposed changes. Sure, there have been problems in certain areas of NC., and no doubt correction or improvement was needed. But it seems the Plan offers no clear cut proven avenues of success, if there were a need for such revisions at all. The Plan?....it reminds me a lot of "throwing out the baby with the bath water". Cost saving? Think again; we feel it is not only unlikely, but in all probability we will loose out on the services we have presently. Hundreds of millions of dollars have been lost by ill-conceived "plans"...and you don't have to go back more that a few years in NC history to see that.	L
Yes, hundreds of millions of dollars...approaching or exceeding a billion dollars or more. Our services here in Asheville are pretty good. We worked for years to help get them that way. Perfect? NO. Will the new Plan take care of remaining problems? Not only is it highly unlikely, but new problems possibly greater magnitude will be introduced in all probability. Around 1989 or 1990, I asked the Deputy Chief of MH in Raleigh at an AMI conference why the Division did no conduct tough reviews of the areas.....the answer? "It's not my job." His response was more that just interesting; it was illuminating. Now, the Plan is going to fix everything. No. we do not concur in the Plan; those needing help are going to suffer if it is forced on them. They don't need "new" problems. Also, existing staff who have worked hard to improve services for years and years....and to build relationships with clients....will suffer. What a reward for their endeavors.	L
I like several parts of the plan, including the evidence based practice and the System of Care for children's services. I am concerned., however, that the plan contradicts itself by emphasizing privatization of services, especially for children, while also emphasizing the SOC approach. While private entities can be trained in the SOC approach, there is not the monetary incentive for the to fully participate and have the level of communications and collaboration necessary to truly implement this approach(this is no a reimbursable service for most private providers). In addition, the state plan states that LME's should consider establishing locations where services can be provided at a central location to consumers with complex needs. Is this not already established in local mental health agencies? Services to children are by necessity more integrated and demand more collaboration across agencies. I am concerned that the plan does not take that need into consideration, and that children will not receive the level of services necessary to prevent long term use of the mental health system.	L
I have worked in this field since 1974, 18 or which was in another state. I am grateful fir all that is done for individuals with D/DMH/SAS but thank you for reading my thoughts. And I want to say this is no reflection on my Area Program, they do a great job ensuring quality care, but truly my individual thoughts as an overview from my perspective	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
Some general observations: consumers who in many cases are employable for longer hours during the week but know that they are restricted by the amount of money they can earn and not lose their benefits. I think the law should change so that they are encouraged to work more, keeping their minds busy, building self worth, etc. as opposed to doing nothing. In some cases, and receiving a monthly check could better serve the individual.	L
I also believe that truly "high maintenance" individuals that necessitate 24-7, should have another option maintained in the community. With expensive "wrap-around services" it is often unrealistic for a person to live in a home of their own or shared with someone else. It may work for some people, but it is generally unrealistic to pour so much money into those that are so difficult to maintain in the community, and in some cases advocate for individuals having a meaningful life, but sometimes reality gets distorted in the name of "individual rights."	L
Also pouring large amounts of money into homes, rent, support staff, for individuals that have demonstrated their inability to live in the community without 24-7 staff, there should be a realistic option looked at that makes sense. Begin immediately aggregate funding for individuals that are receiving CAP/MR. I believe if this had taken place a couple of years back, the state would not be in the hole that they are in now. More individuals could be served with a more realistic view as to Medically necessary.	L
Lastly, less "empowerment for provider agencies" and place more trust into Area Programs. I believe that Area Programs have a better overall perspective as to the "pulse" of what is happening in the life of a consumer. The Providers are generally good people, but money-making, in my opinion, often grays the total picture. Documentation by Provider Agencies are often "a sight to behold". Closer Medication Auditing of Provider Agencies would be welcomed.	L
Even though the Area Programs are responsible, and do a good job monitoring in my opinion, a closer look by the State Officials would help. Again thank you for this opportunity. These are my general thoughts as we work together to ensure the health, safety, and welfare of those individuals we care about. Otherwise we would not be in this field.	L
"Where do the panelists see the clubhouse model fitting into the state reform? If we're going to have LME's. which is supposed to reduce cost but services will be shifted to private non-profits. It will cost a lot to handle the administrative end. I don't see how savings will result. There has to be a certain number in a population to have an LME, which will cause counties to have to combine. Getting the counties to work together may be difficult. Has anyone at the state level thought this out?"	L
"In terms of the state getting information out to area boards, the mental health system has become such a political travesty that information doesn't get down to the front line folk."	L
It seems that information and plans about mental health reform are changing on almost a daily basis, and our observation is that communication practices may not be keeping up with the flow. Certainly communicating across organizational lines can be a challenge for anyone, especially in a rapidly changing environment. With all the different stakeholders involved in this particular process, it would be very easy for communication to become very fragmented and to be incomplete.	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
I am a child psychiatrist at the adolescent unit who also worked in a rural community mental health center for 4 years before joining the JUH staff. I have been very impressed by the medical staff, the ward staff, and the leadership at JUH.	L
I did my general and child psychiatry residency at UNC, and have been very impressed by NC's current system of care in NC and public system. I am writing about my concerns about the state plan and the closing of John Umsted and Dix as a physician who has been involved in the care of patients in NC's public system for the past 11 years. I attend most of John Umstead meeting on Wednesday March 20th and was surprised to hear that there would be no inpatient unit for latency age children in the new hospital which is planned.	L
It truly is a place that believes in giving excellent care to the patients it serves, and it has consistently done very well in survey including the recent Dept. of Justice survey. I am very concerned about this serious deficiency. The agency age child is at times extremely difficult to treat in the community, and there currently are few resources for these children in the private sector. There are times when no beds are available in the state in latency age units.	L
These children are difficult to evaluate and really do require a special set of skills, staff knowledgeable in their treatment, and specialized setting. I am very worried that without any latency age state hospital beds, these small, frequently traumatized kids will be placed in a patient milieu that may include some kids who are much bigger and who may prey on these kids. While these children are at times more difficult to treat, it is crucial to have good evaluation of these children so that good treatment can occur and further problems can be avoided.	L
We have a chance to avoid the development of further pathology with early treatment. We are now becoming more aware of the importance of early diagnosis in illnesses like schizophrenia and bipolar disorder(which are very difficult to diagnose in the young population). As a psychiatrist who worked in the community in a rural community mental health center with a very good leadership, I am also aware that services are hard to obtain in more rural areas.	L
Even with 20 organizations, the services will not be more available to the people live in a remote area and in fact to get to their appointments. I agree that the community services need to be increased, but eventually the reality is that there are only so many people in a community who are willing and able to manage kids in a crisis therapeutic foster respite setting, and some of those kids can't be managed in the community.	L
Additionally, it is often difficult to find the services needed to evaluate these kids in the community. As an Umstead employee, I am worried that a move away from Umstead will mean a great loss of very qualified health care, recreational therapists, and nurses who would not be able to travel 120-30 miles to work. These people are crucial to any hospital, and they would be very hard to replace in Chatham County. The final concern I have is that the hospital will not have enough beds and will not be able to serve NC's growing population.	L
We need to remember that there are places where the largest provider of mental health care is the prison (Los Angeles prison system has that reputation) and that this is not where any of us want our patients to go.	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
I ran across the state plan listed on the web site accidentally this morning and after reading its content was impressed to acknowledge the department for the comprehensiveness of Secretary Odom. The outline addresses many issues but more importantly acknowledges two critical areas. First, the plan recognizes the finite resources of the state which I believe is a major designing flaw in many organizations.	L
To assist individuals at any level you must first designate who can most effectively be assisted with the resources currently available (while constantly searching for funding for other segments of the population). Secondly, the plan notes the diverse socio-economic and culturally rich diversity of our state residents. Diversity is not viewed as an OBSTACLE but as "areas of opportunities" in which creative solutions are explored to find alternatives.	L
Wanted to say that the proposed plan, supposedly in response to a review of NC mental health services, is taking apart what good programs there are in place that are serving citizens with mental health needs quite well and efficiently. I do hope that the planned changes proceed in small steps to assess the impact on community infrastructures including consumer response.	L
Please don't mimic the deinstitutionalization of the 60's that caused much havoc and harm to people with mental illness. I assume that the "reform" will go through regardless of what is said at this time but I wanted to have my meager say. Mental health consumer's are confused as it is and have difficulty, by and large, with transportation and follow-through at times as anyone in the business of helping knows. The fewer steps to care--the better.	L
I am in complete agreement with the need for mental health reform in North Carolina. I also compliment the manner in which your office has been open to comment and suggestions from everyone involved. In reading the November 30, 2001 revision, it was clear that your office has been receptive to public comment particularly from rural and under-served counties such as Carteret County. I would appreciate any and all advice you can offer.	L
There is critical need for a safety net to ensure that staff who are dismissed from one facility as a result of abuse charges are not allowed to go directly to another facility and be hires to work with yet another vulnerable group of consumers. I recognize that there is a registry of individuals who have been convicted, but this registry does not include those whose trial is pending for many months while waiting for a court date. If an individual charged with abuse/neglect, or even more serious charge, is determined by a judge in a probable cause hearing to be appropriately charged and faces superior court proceedings, that person should not be allowed to continue to work in a different location, same kind of work. This is happening probably far more than anyone knows.	L
As an developmental day teacher it breaks my heart having to turn down families who want center-based services because we are the only Dev. Day center in Durham county with only fifteen slots for DD children. Needless to say we have a long waiting list as well as our home based team. If the state or county can't help us currently, can't anyone with some clout help us tap into Dukes endless funding resource and help us expand our program considering most our children come right off their wards?	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
DSS, VR, VA, other agencies do not work together when serving the same person. Cannot receive VR services if you are educated and the job skills of the counselors outside of the Division seem to be inadequate regarding understanding mental illness. There is too much turnover! I've had five case Managers in two years! Always starting over! Consumers often get switched to different doctors and case managers but the new ones do not do good tracking of case histories. Support for people with developmental disabilities needs to be constant and life long. This is not something that comes and goes. Things might fall through the cracks. Consumers have been left out too long. The (system) has been disturbed for a long time. I'm afraid consumers are going to be left out again and will fall through the cracks.	L
1). The PLAN IS NOT USER FRIENDLY AND MATERIAL IS NOT UNDERSTANDABLE. 2). Support in the community is lacking and is extremely vital. 3). Most people don't want to go to LME's (Old Area Program) unless they have no financial choice. Be aware of that. The services, particularly treatment (therapy and doctors) is not as good.	L
4). Too many high salaries at the top need to be spent out somewhere to help the budget problem. 5). MI consumers do not receive enough money to live decently outside and independently. If they are given as gift or work more, it takes away from their benefits. 6). Attitude on the part of the employees and community is the first key to making changes work. Without the right one, nothing will work.	L
7). Keep in mind, that having an open heart to consumer involvement and person centered planning is important in hearing the consumer's voice. However, the consumer is not always right or able to make his/her own best decisions and may need a Guardian. 8). The Office of consumer Affairs needs it's own clear mission statement.	L
9). The State Plan should not be a system of menus and programs but a system of support for consumers and their families and to those in the community, healthy or dependent. 10). Stigma and discrimination is rampant in the community and even among some of those working in the system. This must change!! 11). It "takes a village" to take care of a person with mental illness, particularly severe MI.	L
12). Implementation must be done, not just written. This is very, very challenging. 13). Mental Illness is an individual thing, sex, age, cultural background, education, and diagnosis. 14). There must be adequate molding to the individual, not coloring in the book too tidy. 15). The State and LME's must be willing to go out of the lines.	L
16). People don't like change. 17). People want to go to work and be independent. Social Security puts you back down. They cut your money (benefits) down when you earn money from work.	L
18). Adults with severe disabilities need more support than children at home with parents and who are in school all day. 19). Things might fall through the cracks. Consumers have been left out too long. the system has been disrupted for a long time. I'm afraid consumers are going to be left out and will fall through the cracks.	L
Family members involved as co-trainers, using the models i.e. "Making Room at the Table" and National Family Resource Coalition (national accredited). Purpose of this training is "This is the intent and this is how we get here."(2)	L
Client Rights look different all over the State. How about a "Clients' Rights Report Card" for consistency and unity.	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
(This woman) has a sister in a family care home in Littleton who will be returning to Wake County very soon. Her sister will need a place to live. The sister had previously been at Dix for some time.	L
"Where do the panelists see the clubhouse model fitting into state reform? We're going to have LME's, which is supposed to reduce cost but services will be shifted to private non-profits. It will cost a lot to handle the administrative end. I don't see how savings will result. There has to be a certain number in a population to have an LME, which will cause counties to have to combine. Getting the counties to work together may be difficult. Has anyone at the state level thought this out?" She says she is not hearing much about services; if she's a consumer, she wants to know what's out there. She's hearing mainly about structure and governmental entities. She comments that the state has proscribed a mechanism for the counties to come up with a plan, including county managers, family members etc., but no mental health workers, who are on the front lines. Consumers and front line staff are critical in knowing what is needed. "Are we going to be regulated any less? Too much of a mental health worker's time is spent in meeting regulations. More demands are on area programs, but they are not given any m	L
(This woman's) adult son has been diagnosed with depression and schizophrenia, among others. She's having trouble getting the help he needs. He also has a social phobia that makes it hard for him to leave home to get to the clinic.	L
The implementation timeline currently reflects only the closing of hospital beds for adult services. This is inappropriate unless the state makes a commitment to require the timeline the development of community services before those beds are closed.	L
Transition issues are occurring now as some area programs are losing staff and closing or downsizing programs in anticipation of reform and/or budget cuts. These activities are very frightening to families and consumers. We would urge the Division to more closely monitor service delivery changes that are occurring now, not just those that will be articulated in a local business plan submitted in January. It may be that some transition planning and technical assistance needs to be provided to area programs immediately.	L
The state plan makes a commitment that our system will not differentiate between Medicaid and non-Medicaid clients. As such, the state plan must contain a Contested Case/ Due Process procedure for all clients, not just those who receive Medicaid.	L
(We) commend you and your staff for the dedication and commitment that has been demonstrated in the development of the Plan. The State Plan symbolizes a promise for a better future for consumers of mental health, developmental disabilities and substance abuse services. Clearly, the Plan seeks to provide access for all persons entering the system and streamline services for consumers who seek assistance. We are hopeful that the state will continue to implement the Plan with the thoughtfulness and leadership that you have displayed to date. Nonetheless, although we support reforms, we also believe that reforms should be supported by sound policies that are long term and stable enough to support both consumers and service providers. We fear that the Plan appears to lack the resources to provide the means for true reform. The State Plan should provide a solid foundation for the support and development of quality mental health, developmental disabilities and substance abuse services throughout North Carolina.	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
<p>In order to accomplish this goal, we recommend the following: The state should: Make a strong commitment to mental health by providing adequate funding for the transition of consumers from state institutions into the community. Funding priorities include providing stable and recurring funds to localities for service provision, and the restoration and expansion of the Mental Health Trust Fund. With the passage of the Mental Health Trust Fund, this past legislative session marked a major victory for mental health in NC. Nonetheless, this progress might be undone because of the state's current financial crisis and the agency cuts associated with it. The trust fund's purpose was to provide bridge funding for community services for consumers leaving state hospitals and re-entering the community. Yet, due to the current financial crisis, Governor Easley is withholding \$37.5 of the \$47.5 million of the funds originally earmarked for the Mental Health Trust Fund. Because of the limited state dollars, it is unlikely that the State Plan can be fully implemented if we cannot keep the funding commitment to Mental Health.</p>	
<p>Therefore, bridge funding will continue to be an issue with the current status of no new dollars, the reality of community-based services may be difficult to achieve. The services that span the continuum of care are absolutely necessary to ethically and competently serve clients. There must be access to residential services, inpatient stabilization services, partial hospitalization/day treatment services and outpatient services. Attempting to provide mental health services in the community is best practice. However, it will be harmful to consumers if services are not adequate and funding is not available to provide efficient and effective services.</p>	
<p>Ensure the existence of adequate provider networks in every part of the state and provide technical assistance to localities on building provider networks. The State Plan proposes that communities will be responsible for the care of citizens. Currently counties rely on state facilities for many of these services because community provider networks are non-existent. Though we applaud the provision of services in the least restrictive environment, we are concerned that the Plan is relying on a service provider system that is inadequate and needs state leadership to develop. Many counties in NC have weak service delivery systems because there are not enough service providers. This is especially true in rural parts of North Carolina. Moreover, the limited providers who are in these rural areas are not likely to accept these consumers because of insurance reimbursement rates and complex diagnoses without the needed support services and effective treatment options.</p>	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
<p>Promote client-centered practices by providing treatment in the most therapeutic and least restrictive environment. Pursuant to the Olmstead decision, we believe that consumers should receive care in the least restrictive and most beneficial environment. Community resources need to be in place before persons begin to attempt to access services in order for this plan to succeed. Support providers so that concerns of increases in overhead costs, potential loss of state employment benefits and possible increases in liability are addressed. As services become community based and as area authorities no longer employ direct practitioners, the majority of whom are social workers, must be supported. Many social workers are looking at forming or joining private for profit or not for profit agencies in order to continue providing services. However, rising concerns over low Medicaid reimbursement for practitioners and potential lack of community funds for services threatens the ability of practitioners to adequately provide service in the community setting.</p>	
<p>In addition, practitioners may be forced to take on administrative tasks and consequently limit the time they have actual consumer contact. Many of the administrative duties (e.g., Medicaid billing, reimbursement and obtaining services for clients through Value Options) associated with changes in the provision of local mental health services may fall on the practitioners and not on the LME's. Overhead will increase for existing agencies and will be higher than the current market allows for those that are being formed. Again community based services are most appropriate but for the Plan to be truly realized, the financial support must be in place. As a result of the shift in the provision of mental health services at the community level, the provider has increased responsibility to assure that the consumer receives appropriate and necessary services. There is the potential for increased liability for the provider should the consumer not receive these services.</p>	
<p>We are pleased to learn that the new Division plan identifies racial and ethnic minorities and people living with HIV/AIDS with mental health needs as priority populations for mental health services. We agree that changes to the mental health system's infrastructure are essential for addressing disparities in access to mental health services. Requiring cultural competencies at all levels of staffing, modifying service delivery protocols to best serve racial and ethnic minority clients by promoting faith-based and community-based organizations as credentialed providers and ensuring diverse community representation in strategic planning reflect the visions of DMH/DD/SAS and MHAC to best serve North Carolinians. We applaud the Division's efforts to ensure accountability of local entities to address mental health service needs of racial and ethnic minorities and underserved populations in business plans evaluations and report cards.</p>	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
<p>I am a resident of Guilford County and member of NAMI NC. I am sorry to report that, as far as I or other NAMI members know, the administration of Guilford Center has made no plans nor preparations for local citizen input or a Consumer & Family Advisory Committee. I spoke with Peter McKenna, a member of the Guilford Area Board who is also a NAMI member, and he told me that the Area Board has received no information about such a process or committee. It appears likely that in Guilford County the development of a business plan will not follow state guidelines. I wonder what will be the consequences, if any, if Guilford County does not "get with the program" and submit a plan consistent with state requirements. My second concern has to do with Client Rights. I have served on the Client Rights Committee in Guilford County for several years and have found it to be increasingly frustrating. I feel that Client Rights Committees should report to a state level office rather than the local authority which has an obvious stake in the findings and activities of CR Committees.</p>	
<p>Area programs retain approximately 5000 staff across the state. These transition issues will serve as barriers to successful implementation of the state Plan without careful, thoughtful deliberation by DHHS and the General Assembly.</p>	
<p>The state plan (as posted on your website) is not user-friendly. When I pull it up it is nothing but nonsense. What program is this stuff written in, and why is it not posted on the first page that a specific reader program is required to read or print these documents????</p>	
<p>Again, family members are given hope of real system change. This can happen when all parties become partners in building a system of services with our resources available. And advocacy organizations, clients of the system, staff of the mental health system at all levels, and our elected officials are important RESOURCES in this process! Family members want honesty and openness. Don't keep us in the dark.</p> <p>1.How can one explain the disparity regarding respite care for parents of children, when Medicaid will pay for respite if the child's diagnosis is mental retardation, but not pay for respite if the child's diagnosis is an Axis I diagnosis of mental illness?</p>	
<p>2.How can one explain the disparity regarding an adult with a mental illness diagnosis on SSDI and not having the money to pay for necessary medicines, when Medicaid will pay for medicines of those with mental retardation, or those in a hospital or group home? It would be cost effective to make sure those with mental illness on SSDI can get needed medicines without having to go to a group home or hospital or turn to street drugs/alcohol. Some can recover to the point that they could live at home, and work, with needed supports. I understand in some states, Medicaid pays for anti-psychotic drugs for those with mental illness. Why not in NC? 3.Just this year, as we are promised system change, it took the folks in the state office until February (money could have been available in the fall) to sent out the guidelines for proposals to access the 2% CTSP funding for family involvement. After February, when proposals were written using guidelines, we are now (in April) told the guidelines are being changed! – and this money, if we ever see it, must be spent this fiscal year, by June 30!</p>	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
<p>Laughable, if it were not so serious! This is unacceptable from folks at the division level orchestrating system change. Is this a statement of their value of family involvement! This is money that could have been used all over the state for the past several months for education of parents and getting them involved in their important role as a partner in system change. I believe family members have a right to know who has put a stop to funding which had been allocated for family involvement! If this sort of thing happened in the business world, there would be folks losing their jobs! Clients of the system deserve better, and have the right to expect more of the state leaders at the division level! WHO CAN HELP US WITH THIS?</p>	
<p>4. Please use the same names for roles/groups giving opportunities for family members to participate! Is this orchestrated confusion to "keep us in the dark"? What is the status of the Consumer Advocate at the state and local level? What is the name used for the group of consumers and family members who will participate in the writing of the local business plan? Is this the same group (what is the name of this group?) who will continue to monitor the plan and report directly to the Secretary? Is all this confusion necessary? Thank you for the improvement made. We are now given opportunities for input. However, there is more work to do, and clients and their families are eager to help!</p>	
<p>Stakeholder Involvement 1. How do we get the opportunity to be on the State Family and Consumer Advisory Committee? What is going to be the procedure for how these people are chosen? 2. State objective 8.1e, DHHS will assess readiness of DHHS for system reform. Needed changes will be gathered and followed through to completion with the quarterly progress report to the Secretary. 3. How will consumers know about the quality progress reports done quarterly? 4. How does the Plan make sure that consumers and family members will not be picked [for advisory boards] because of politics? Is this addressed?</p>	
<p>Continuity 1. Will the Community Collaborative for Child and Family Service continue after the Plan goes into effect?</p>	
<p>Providers 1. Will Tri-Care be affected by the Plan? Tri-Care is a military insurance program like Blue Cross and other companies that approve for individuals to see a provider. 2. Where will consumers get the information they need to choose [providers]? 3. Will there be a way for any consumer to find a provider? 4. How can a private provider see someone who does not have insurance? 5. How will [all consumers] be served [in the community]? There are only about 3 doctors in [my county] who do not work with [the area program]. There are not enough doctors in [my county] who work with people with mental illness.</p>	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
LME's 1. What does "contract" really mean in reference to not only the LMEs' contracts with providers but also the contract for crisis services? 2. Who screens you? 3. What does "contract" really mean in reference to not only the LMEs' contracts with providers but also the contract for crisis services? 4. Will the centralized database require constant reauthorization from the consumer? 5. Will there be an 800 # other than for Crisis and the already existing Care Line, such as for uniform portal referral calls? 6. Where will [my county] fit in? Regarding the example of more than one county joining together: Would the county commissioners of one county determine what happens to the other two counties? 7. What will LME do and will not do? 8. Will the county have everybody's name that goes to the clubhouse?	
Best Practice 1. In the State Plan Implementation section, it says that all components of the system must be clinically effective and operated efficiently and that services and supports will be evidence based best practices and/or meet national standards of service delivery. Regarding Best Practice -- with what money source? Who will pay for Best Practice?	
Services 1. Are all citizens of NC qualified to receive services? 2. Most people in clubhouses are highly functional. What will they do about medications, etc.? 3. What is an ACT team?	
Access 1. Will the centralized database require constant reauthorization from the consumer? 2. Will there be an 800 # other than for Crisis and the already existing Care Line, such as for uniform portal referral calls? 3. Will there be case management at the LMEs that will come to your home? 4. How come they are building so many rest homes, group homes? 5. Will they build efficiency apartments? 6. How come they are building so many rest homes, group homes?	
Target Population 1. Will people lose services if they are stable but will "decompensate" without such? 2. If a person (advocate) knows a person who thinks he/she has been discharged prematurely, [where would the advocate look in the Plan to find out what to do]? 3. What if the mental health center says you need to come just once a year? 4. Will [consumers] never go back to clubhouses or to the Area Program? 5. If a patient is evaluated and he is recovered, will they take away his medicine? 6. How do you prove and to whom that you will get worst off? We need to know.	
Quality Assurance/Quality Improvement 1. How will the Report Cards be done? 2. State Business Plan Section -- page 17 Objective 6.3 Develop and maintain highly competent staff. What will promotion and training strategies be? 3. Regarding the core function of screening: How will folks know that the screeners will be well qualified and give the right answer?	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
GENERAL COMMENTS	
<p>Funding 1. How many visits will Medicaid allow for therapy? 2. What will medically necessary mean for mental illness issues? Can Medicaid expand this beyond what DD has, etc. for different illnesses and disabilities? 3. During the screening, if a person is found to have needs, will that person be referred to someone based on insurance (coverage) and what if there is none? 4. Regarding waivers for TBI -- will persons with TBI still be eligible or not? 5. What about home and community waivers? 6. Regarding the development of community - based services, from where will the money come to do this? counties? 7. What does a person do if they do not have any insurance or Medicaid? Will they be left out in the cold?</p>	
<p>Core Functions 1. Will consultation be given during screening if that's the last core function for a client? 2. Are Area Core Functions available to people who are insured and to those who are not? 3. Regarding the core function of education: What type of education will they be offering?</p>	
<p>General Questions 1. Is there still going to be involuntary commitments? 2. How do we know this plan will work? 3. When does the State Plan take effect? 4. If a person (advocate) knows a person who thinks he/she has been discharged prematurely, [where would the advocate look in the Plan to find out what to do]? 5. A consumer was "wondering about non-Medicaid appeals." How does one make an appeal if I think something wrong has been done? It needs to be stated plainly in the State Plan. 6. Where will my child go after leaving the Program for autistic children at Murdoch (PATH) if he is still not ready after two years to function sufficiently at home? I want him at home but it was a disaster before. My other son who has autism functions well living at home. All autistic children are different depending on the behavior aspect. 7. Will the wonderful, best working Program for autistic children be a part of the downsizing? 8. Is the Division Director a psychiatrist?</p>	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
Consumers	
Again, thanks for the opportunity to provide feedback. I am interested and willing to serve on a committee at the state level if such a committee is formed to ensure that family member perspectives are factored into the implementation and evaluation of the our state's reform efforts.	H
Thanks for your time and effort in listening to this consumer/family member's comments on the New State Plan. It's much appreciated.	H
I am telling you how I feel about the mental services. We need to keep them. Don't stop them.	
Thank you for the opportunity to provide input from a family member in your efforts to design and implement the state plan for mental health reform. My comments are based on firsthand experience with the mental health system at the local and state level. There is much work to be done, and I appreciate your efforts to address issues, obstacles and tragedies that have been too long ignored. Again, thanks for the opportunity to provide feedback. I am interested and willing to serve on a committee at the state level if such a committee is formed to ensure that family member perspectives are factored into the implementation and evaluation of the our state's reform efforts.	
I appreciate this opportunity to have input into the state plan. As the parent of an adult with severe developmental disabilities including autism, I feel that CAP slots must be maintained for those with the most severe disabilities, especially adults who live with or have older caregivers. Family members of those individuals with most severe disabilities must have the option to participate in the assessments. Because half of the individuals with autism are nonverbal and most, like my son, also have mental retardation, input by people who know them best is essential. I urge policymakers to maintain CAP support for individuals currently funded even in these times of current financial difficulty. Also, do not tighten Medicaid eligibility; rather, encourage individuals with disabilities to work, through Supported Employment, and increase income without losing Medicaid eligibility.	
I believe I sent an email a few months ago expressing my 100% support for the new State Plan. I am a single mother of a 10 and a half year old autistic boy. His father lives in the area, but due to his personality and working schedule we do not get much help from him. My son has been on the CAP's waiting list or single portal for over 2 years. The only services he was getting other than resource & language/speech therapy at school are those from the Arc of Orange County such as respite care. This is based on a sliding scale fee which is determine by people's income and mine is rather low. Since we relocated to Durham County I have been trying to get services for my son through the Arc. However, things are done a little differently here as people must go through the Durham Center and they refer those clients to the Arc. We have no relatives nor close friends in this area. There are too many people out there in desperate need for services.	
The State Plan is the best thing suggested and it surely should be implemented. It is very hard for parents of autistic children like me who deal with them day in & day out when you do not have anyone giving you a hand. Please help us!!!	
I think that the annual progress report on addressing disparities in the MHDDSAS system should be widely publicized. In fact, you could use the publicizing of this report as a way to do more outreach through all forms of media. Copies of this report might well be distributed in such places as Social Security Offices, Food Stamp Offices, doctors' offices, clinics, emergency rooms, etc. to publicly acknowledge the problem and show that we are trying to address it.	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
Consumers	
We have been on the CAP waiting list now for 1 1/2 years. I believe we got a revisit form only once since we signed up. Our understanding is there will be no more CAP slots. My suggestion is to find a way to keep the families informed of the status.	
My biggest complaint is that we are spending a lot of money in North Carolina to people that are substance abusers. I realize they need help but why deny those that were born with no choice of mental disabilities they funds for people who choose at the onset of their problem to abuse alcohol and drugs. Does that seem fair? god made these mental disabilities not people.	
There are so many families out there that need these funds that have no hope of ever getting any help from the appropriate sources. I can't say that for the substance abusers especially those who have been on the program for years and are allowed to continue. All we are doing is helping them continue their problems.	
As elderly parents of an adult bipolar son my husband and I have had the fear of our life after reading the outline for the mental health reform project. Mentally ill people cannot think clearly they cannot focus on strategy for change. My son could never find a private provider. He cannot work; he is on Medicaid. The Neuse Mental Health Center is a safe place. He can learn how to live and rely on the information there.	
This plan is unstable, however changing, not proven, and unreal in the terms that there are not enough psychologists and psychiatrists to go around. After we die who will find all of the private providers he will need. I predict that mentally ill people will either go to hospitals or to jail. All the comforts of home will not be available! Thank you for reading this letter.	
I am a single mother of a 10 1/2 year old boy diagnosed with autism. I will not be able to attend any of the 4 family member group meetings to be held in Raleigh due to distance and family responsibility. However, I'm sending this email to express myself somehow and offer an input or suggestion. The purposed plan sounds ideal and fair for all peoples with disabilities, etc.	
Please take in consideration some of these people have severe problems which not only affect them, but their families as well. There aren't enough sources out there to give most of these people the services they really need so many are being left out. We have the right as tax payers to get services when needed regardless of financial means. Please see this plan gets established. It would be a wonderful thing for us all.	
I think it is very important to consider the definition for respite and enable the parents to use it for planned activities. If the parents are fortunate enough to be involved in a planned activity such as Bible Study group, dinner theater, card games, etc. that is what respite is truly about. A chance to be away from the responsibility of the child. I also believe that siblings should be included for outings if the child's goals supports the inclusion. My child is 1 year younger than his brother with DD. I try very hard to find time to allow them to interact safely.	
My son with DD gets to go everywhere because he has a worker. He has goals to play and interact with his brother but cannot unless I can go along. When I go along, my son with DD will not participate in the activity because mom is there and he wants to be with me. It is also very difficult to explain to his brother why he can't go, too. Obviously this would need to be scrutinized closely. A significant amount of his budget is allocated to pay Southeastern Mental Health for case management services. I believe this could be done through them. Thank you for your consideration and all the work you do.	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
Consumers	
Specific comments regarding the State Plan are as follows: Coordination of Services: We continue to emphasize that coordination of services needs to be not only between the three disabilities but also the multiple agencies such as Education, Justice, Health, etc. who are involved in the services provided to the consumer. Housing: We want to emphasize the importance of having appropriate housing available, especially for the substance abuse population. This includes working closely with the various housing groups/organizations such as the North Carolina Housing Finance Agency, housing authority, etc.	
Cost of Services: We continue to have questions regarding where will the funding come, i.e. county, State etc. We are also concerned about what other agencies may perceive as unfunded mandates when MH/DD/SAS clients return to communities with additional needs other than their MH/DD/SAS problems, i.e. housing, educational, medical and judicial problems. Housing: We want to emphasize the importance of having appropriate housing available, especially for the substance abuse population. This includes working closely with the various housing groups/organizations such as the North Carolina Housing Finance Agency, housing authority, etc. Simplify the Consumer/Client Rights/Ombudsman Process-We continue to recommend that areas of duplication be discontinued and processes be streamlined.	
Providers: A consumer expressed the concern that although she is getting services now, she is afraid she will not get services under the State Plan because she does not have finances.	
Quality Assurance/Quality Improvement: Consumers and families all over and hired in the system, including the Governors Office need to know when to call there for help, resources or referrals and when not to. Many physicians aren't educated about MI and that it may be neurological.	
Services: Transportation is generally a problem but was not as much an issue for Those who attend the meetings. Clubhouses has kept me out of the hospital, has kept me stable. My doctor is for clubhouses because they keep people out of hospitals-saves Medicaid money. Clubhouses help people not needing to go to the psychiatrist. Coming to the clubhouse helps me deal with life.	
The definition of Respite is too tricky and narrow, it needs to be broadened to allow with freeing time with the non-disabled child/children. Respite should help with freeing up a parent even if it is scheduled time i.e. childrens' ball games, church, or else we can not meet the needs of the siblings. Need "drop-in" Centers where you can go anytime to socialize and have a cup of coffee. We currently have many people who have autism who cannot be served in the community because of the intensity of their needs. Screening may only be through a 1-800-number and not a real person to person conversation. Strong concern about beds closing and people not getting services in the community i.e., in a rural county, who will pay for services that a poor county doesn't have? We need more details about this in the plan. 700 total beds being closed including Whitaker School. Medications keep you out of the hospital.	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
Consumers	
<p>1). A disabled person who understands and is not a trained professional or a political appointment must lead Consumer Affairs Office. 2). The consumer and families must be involved in the Report Cards. 3). Some family members and consumers may merely be tokens. Boards who have hidden agendas and prejudices choose some. 4). Squeaky door gets oiled .Mentally retarded and some Autistic adults have difficulty communicating. Some are unable to talk. 5). I think it (State Plan) needs to be simplified for consumers and families because even the professionals don't understand it.</p>	
<p>1). Though conversion of public to private services should require verified consumer, family, and other stakeholder input into written, publicized plans and widely-held public hearings, advertise well in advance of legal actions, such public input has not existed in the Blue Ridge Area Authority catchment area. Communities deserve "self-determination" in choosing between public and private services. Semi-secret plans to covert public services to an area authority created, funded, independent, private, non-profit with no written plans to study should be illegal, Do not allow hasty area board approval of privatizing recommendations, backed by lack of crucial information on local plans and based on scary interpretations of State Plans, while the public majority is unaware of the elimination of our public "safety net".</p>	
<p>3). Nine members for each LME consumer and family advisory committee seems to be enough representation for mental health, developmental disabilities, and substance abuse, especially if the LME contains at least eight counties. How will each county be assured of adequate consumer and family advisory council representation, whether urban or rural? Is this fair? "All Consumer and Family Advisory Council representatives for mental illness for our LME will come from Buncombe County (i.e. more choice of advocates) versus rural counties", and "All present advisory councils must be disbanded", regardless of current effectiveness. Consumer and Family Advisory Council members should not be chosen by LME county commissioners. Consumers/families, not currently receiving services, should (but will not) have opportunities to serve on LME boards and advisory councils; their input would be valuable! Consider: perhaps the family member died or, maybe, services were inadequate.</p>	
<p>4) LME performance of Best Practices in Client' Rights and of Best Practices in Monitoring of contract agencies and of LME facilities (if applicable) should be included on report cards when they become a reality. Regular, on-site monitoring of LMEs" should verify all LME reports. "Qui custodiet custodes?" Who keeps an eye on the watchman??</p>	
<p>5). Clients' Rights and Monitoring were to be more fully developed and described after the State Plan was distributed. Please assure that clients' rights committee members and sub-committee members receive all additional clients' rights information, so that consumers, families, and current clients' rights committee and sub-committee members have ample opportunities for input into State Plans. At this point, chairperson and members current clients' rights committees do not know what their LME pilot's plan in regard to future clients' rights committee plans might be, nor have we had opportunities for local input.</p>	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
Consumers	
<p>6). Quarterly regional training at multiple sites, and/or on-going training opportunities by means of 2-way televised classes (available at various committee sites, especially colleges), accompanied by Annual Clients' Rights Conferences, should be considered as a possibility for regular training for clients rights committee and sub committee members. Such means of training could also be made available for Consumer and Family Advisory Committees, for Ombudsmen, LME staff, etc. Many persons in need of training live too far away or cannot afford trips to Raleigh, especially during times of low budgets. Films and written materials would also be helpful. A manual with legal clients; rights information (for laymen) is needed. What about direct, on-going communication between the Division of MH/DD/SA and Clients Rights Committee and Advisory Council chairperson to ensure that they receive appropriate information and support, especially when there are local problems? There is much too much inconsistency among clients' rights committee in NC; and advocates would like to see more consistency in clients' righ</p>	
<p>7). Through board member terms were described in Bill 381, LME membership limits should be for two terms, out for at least one year, then available for re-appointment. Even well educated board members take at least one full term to learn what they need to know. Too much board member turn-over contributes to board ignorance and unwise decisions. The NC Council for Community Programs gives excellent board training; but not enough board members receive the benefit, especially those who live farthest away. Too much local board training on how services are provided by staff often outweighs limited local training on board members' jobs. A certain amount of proper training, such as NC Council gives, should be required for all LME board members. Since County Commissioners have been charged with additional responsibility, they should receive adequate training.</p>	
<p>The plan needs to define adequate family/consumer involvement. Simply holding a public gearing is not adequate involvement. Families and consumers need to have a meaningful role in the planning and decision-making. The local plan should include not only how families and consumers were invloved in the planning process, but what measures were taken to educate families and consumers about the process and community options. the local business plan should identify who was represented on this advisory group, how they were choesen, and how input was solicited and responded to.</p>	
<p>The section of the state plan dealing with consumer and family involvement is weak on specific implementation requirements. Implementation dates are needed around the establishment of the Office of Consumer Affairs, the Ombudsman Program, and client rights committees and how they will all coordinate.</p>	
<p>I appreciate this opportunity to have input into the state plan. As the parent of an adult with severe developmental disabilities including autism, I feel that CAP slots must be maintained for those with the most severe disabilities, especially adults who live with or have older caregivers. Family members of those individuals with most severe disabilities must have the option to participate in the assessments. Because half of the individuals with autism are nonverbal and most, like my son, also have mental retardation, input by people who know them best is essential. I urge policymakers to maintain CAP support for individuals currently funded even in these times of current financial difficulty. Also, do not tighten Medicaid eligibility; rather, encourage individuals with disabilities to work, through Supported Employment, and increase income without losing Medicaid eligibility. Thank you for your consideration.</p>	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
Consumers	
<p>A former Campbell University professor told the audience they were not getting the truth about the new bill. He has a disabled daughter in the HPE program in Lillington where she performs low-skill tasks for a small wage "You are planning to put our people on the streets and emptying our people out of the facilities. We need to let them know we don't like the program." He said the new reform legislation was designed with the Charlotte and Raleigh areas in mind. Therefore, registered voters should consider "getting rid of them (elected officials) and elect those who will do the job."</p>	
<p>I thought this might be something that everyone should read. With what we are trying to do in this state now and with the budget cuts looming over our heads, this kind of puts things into perspective of what the actual life is like for a person with a disability and the families that are struggling to take care of our loved ones. Our state leaders need to hear these stories. We have some really wonderful leaders that are trying and succeeding to understand what we go through. But there are as many or more that do not. Hopefully this message will get out to all either by email or by it being read at one of these meetings that are going on right now to decide our fate. Please read and feel what is happening in these homes, and have an open mind when a parent or person with disabilities is trying to tell you why they are defensive or aggressive at meetings. Try in some small way to understand why we feel such an urgency to make changes because maybe we won't have a week or month or years to see this happen with our loved ones. It to us is a state of emergency. We hope that through this small window of our lives you</p>	
<p>We now have a hope that was never there before with our previous leadership that our New Leaders are knowledgeable, determined and strong enough to stand up with the wonderful staff that has always been there behind the lines fighting, and will do the right thing. Just remember we are not the enemy. If nothing else we are the experts on what we need or don't need. We only want to help. Thank you for all that you are doing with us and please remember this should be a PARTNERSHIP.</p>	
<p>Where Are the Parents? By Sue Stuyvesant They are on the phone to doctors and hospitals and fighting with insurance companies, wading through the red tape in order that their child's medical needs can be properly addressed. They are buried under a mountain of paperwork and medical bills, trying to make sense of a system that seems designed to confuse and intimidate all but the very savvy. Where are the parents? They are at home, diapering their 15 year old son, or trying to lift their 100 lb. daughter onto the toilet. They are spending an hour at each meal to feed a child who cannot chew, or laboriously. And carefully feeding their child through a g-tube. They are administering medications, changing catheters and switching oxygen tanks. Where are the parents? They are sitting, bleary eyed and exhausted, in hospital emergency rooms, waiting for tests results to come back and wondering: is this the time when my child doesn't pull through?</p>	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
Consumers	
<p>They are sitting patiently, in hospital rooms as their child recovers from yet another surgery to lengthen hamstrings or straighten backs or repair a faulty internal organ. They are waiting in long lines in county clinics because no insurance company will touch their child. Where are the parents? They are sleeping in shifts because their child won't sleep more than 2 or 3 hours a night, and must constantly be watched, lest he do himself, or another member of the family, harm. They are sitting at home with their child because family and friends are either too intimidated or too unwilling to help with child care and the state agencies that are designed to help are suffering cut backs of their own. Where are the parents? They are trying to spend time with their non-disabled children, as they try to make up for the extra time and effort that is critical to keeping their disabled child alive. They are struggling to keep a marriage together, because adversity does not always bring you closer. They are working 2 and sometime 3 jobs in order to keep up with the extra expenses.</p>	
<p>And sometimes they are a single parent struggling to do it all by themselves. Where are the parents? They are trying to survive in a society that pays lip service to helping those in need, as long as it doesn't cost them anything. They are trying to patch their broken dreams together so that they might have some sort of normal life for their children and their families. Where are the parents? They are busy, trying to survive. [Permission to duplicate or distribute this document is granted with the provision that the document remains intact.]</p>	
<p>I would like to endorse the position paper that the North Carolina Mental Health Consumer Organization has sent to the Mental Health Project Team as a list of my own personal concerns regarding the new state plan.</p>	
<p>The committee now reviews behavior plans and accomplishes little else in the way of monitoring clients rights or contributing to the improvement of services. As I look at the plan, I look for a mechanism that would ensure the legitimate functioning of CR Committees. As long as these committees are required to answer to the administration and board itself, and serve only at the pleasure of the area director, integrity to purpose does not exist. Such committees should report to the state advocacy office, or some other body outside the local program. Otherwise we continue to have the fox guard the hen house, which is meaningless with regard to contributing to quality services.</p>	
<p>Is the Citizen Advisory Committee the same as the Local Family and Consumer Advisory Committee? Is one a subset of the other? Are they two entirely separate entities? Who decides the constituency of these committees? What is the mechanism that ensures that these committee members are not selected solely by the current area administration? How will the plan ensure a voice for those closed out by a heavy-handed and intimidating Area Director?</p>	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
IMPLEMENTATION/ STATE & LOCAL BUSINESS PLAN	
Persons with SPMI are among the very most needy in terms of Medicaid eligibility. The cost of the necessary antipsychotic medications prohibits many persons with mental illness from getting adequate care. It is time for North Carolina to overhaul its Medicaid system to ensure that people with SPMI are eligible for Medicaid. Those who are ineligible because of their SSDI check are falling through the cracks. The SSDI check cannot possibly cover the costs of antipsychotic meds. And the calculated spend-down is at a level that is mathematically impossible. The formula for calculating the spend-down for these folks needs to be changed so that eligibility criteria can be met. For my brother, that is impossible.	M
I concur with statements made during the media interview that normal attrition arising from retirement, personnel turn-over, placement with private contractors, etc. will help to minimize the actual numbers of state employees subject to RIF. However, I know from first hand experience that there are many, legitimate employee concerns not addressed by the Plan or adequately addressed by current State Personnel Policy.	L
For that reason, I would encourage the Project Team to add a Human Resource component to the Implementation Plan. This is needed not only to address state employee concerns not otherwise covered by existing law/policy/regulation, but could well prove invaluable in ensuring a smooth transition to quality, community-based services by providing a highly skilled workforce. Workforce issues have been a primary factor in problems experienced by current community programs and in states where transition to community-based services was less than successful.	L
Some broad topic categories identified by the SEANC Privatization Subcommittee several years ago included items listed below. Some might be accomplished through administrative action, while others would require legislative action. 1. DHHS/OSP Meetings with Agency Employees to discuss impacts, concerns, employee rights and current RIF benefits. 2. Minimizing Reduction-In-Force a. Enhancement of Discontinued Service Retirement Allowance b. Early Retirement Incentives 3. Legislative Enhancements of a. Priority Re-Employment Rights b. Payment of Unused Sick Leave c. Relocation Expenses 4. Continuation of Health Insurance Benefits 5. Job Retraining (Use funds from current programs to assist in re-training current State employees or provide free tuition/financial assistance based on years of service to return to college. College tuition could even be linked to Educational careers to assist with the teacher shortage.) 6. Priority Re-Employment with Private Service Providers 7. Improved job placement assistance including private job placement services.	L
Thank you for considering these suggestions! I believe implementation would do much to re-assure state employees that DHHS remains committed to not only our citizens with developmental disabilities and mental illness, but to those who have dedicated their lives and careers to serving them.	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
IMPLEMENTATION/ STATE & LOCAL BUSINESS PLAN	
Dear Team Members, I will keep my comments as brief as possible; first I would like to applaud the efforts of the team in producing a much needed first step in the improvement of the delivery and administration of mh/dd/sas services in NC. While I am in total support of the Reform Plan my one reservation is that it does not do enough to address some of the problems inherent in the current Area Program system which appear to be repeated in the LME structure. Specifically, we must have Direct Enrollment/Billing for Private Providers-the redundancy and poor fiscal management found in many AP's should not be allowed to repeat itself in the new LME structure. The same can be said for having 20 LME's; my reading of the Plan leaves me wondering why the continuation of an administrative expense which could be controlled even further by not supporting 20 new admin entities. The goal of a true system of continuity of care could be more easily met with fewer administrative units in place. 20 LME's could function with as much disparity as some of the current AP's.	M
I understand there is much in the Plan to control for this, but the simple fact is it is easier to standardize the operations of a few versus "the many". Again thanks to all members for their time and efforts and I look forward to continuing planning for a "new day" for the consumers and families of NC's MH/DD/SAS system.	L
We suggest that the state go back and rethink this whole plan! (6)	M
There appears to be a clear expectation that counties will end up being financially responsible for providing services to those people who have historically relied on services, but who now fall outside the target populations or who want a service outside the approved array of services. Is this accurate?(1)	H
There is concern that if downsizing state hospitals is driven by an arbitrary schedule, then the state hospitals will "dump" these individuals on the communities without adequate services or funding being in place.	H
Who will provide the overall supervision/monitoring of the private providers?	H
Why are there so many unknowns in the State Plan? It suggests that they (the State) don't really know what they are doing, which is scary because the devil is in the details that have yet to be explained. (7)	L
There is serious ethical concern about the way that Mental Health care is being compromised by purely financial considerations. (4)	H
Is the State immune from class action lawsuits? (1)	L
What happens if need exceeds the funding available for even acute care; do we set up priorities for the most acute of the acute? (1)	L
What is a viable outcome under the State Plan? Is it the State's desired outcome or the desired outcome of the people being served? (1)	L
Change your name from Carteret Family Services Center, to something that better expresses what you do. (1)	L
What will happen to the money that is saved when an individual is discharged from the institution to the community? Will the money follow the person to serve as bridge money during the transition? (3)	H

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
IMPLEMENTATION/ STATE & LOCAL BUSINESS PLAN	
There is serious concern about the requirements (competencies) that private providers will have to meet in order to provide services, and concern about who will be providing adequate oversight. (3)	H
A role for the LME should be that of grant writing to supplement the financial needs of the local service system. (3)	L
We need more county involvement with, and support for, services.	L
We need more involvement from self-advocates in providing oversight/monitoring. (5)	M
We need to develop public/private partnerships.	L
How can we attract/develop Substance Abuse providers in our (rural) area? Transportation is a problem and there are no providers in outlying areas. We need satellite offices. Consumers are sometimes unable or unwilling to travel the distance to the outpatient center in Morehead City even if they do have transportation. Many do not have transportation and Carteret County Area Transportation System is insufficient. (2)	M
We are concerned about SSI and SSDI and how these federal financial supports continue to serve as disincentives to employment and meaningful recovery. The State Plan does not do anything to address these issues, yet they undermine the Plans focus on recovery. (3)	H
How can we move towards this new system with no Mental Health Trust Fund money to use as a bridge to move people out of the institutions and into the community? The Governor just took over 75% of the Mental Health Trust Fund back and the State Plan is based on no new money! It won't work without the money! (4)	H
"This all boils down to Money. Nobody wants increased taxes, but we may have to cope with increased taxes to get the services that are needed." (3)	H
As we look at accountability and outcome measures, what will we consider a statistically significant success rate? And by whose desired outcomes will we measure success?	M
We are concerned with politics in Raleigh that control the funding streams. Consumer needs and preferences are NOT their priority! (1)	L
The counties are worried about how they will provide the extra money to fund programs that the state will no longer be funding. (1)	H
To get high quality services we need better pay for the people who provide the services. (2)	L
There is a need for technical support for helping communities to come together to plan service delivery under the new system. (2)	L
There is already a need for increased funding for extended support and services for supported employment consumers. How is the State addressing this need? Currently Area Programs or private providers eat this cost. (1)	H
Current funding (CAP/MR-DD) does not distribute money out equitably. Aggregate waiver funding, instead of "slot funding," would spread the money out more equitably and serve more people. (8)	M
Monitoring concerns: Who will do this, and based on which standards? This is essential! (5)	M

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
IMPLEMENTATION/ STATE & LOCAL BUSINESS PLAN	
How can we be sure that the LME is actively soliciting input from consumers, family members, and advocates? You haven't been able to achieve this up to the present time, need I remind you... What penalties will be assigned to LMEs who do not do this? I think that it is a direct conflict of interest for BRAA to start a new private, nonprofit agency to take over the mental health and substance abuse services while AT THE SAME TIME applying to be the LME which will oversee them. They lack sufficient oversight already; if part of BRAA becomes private, then they will not get as much oversight as they do now--which is damned little and terribly insufficient. I realize that these are local problems with our Area Board; however, I doubt if we're the only one in the State with at least some of these power-lusting fools in them.	M
I would add "Sufficient consumer, family member, and advocate participation in all system reviews, planning, reports, councils, etc." to the items listed under "Performance Goals." I really do want to know what the penalties will be for LMEs who consistently ignore and/or don't have any input from consumers, family members, and advocates. There must be some REASON for them to recruit and maintain effective working relationships with CFACs. They aren't going to do it out of the goodness of their hearts. You keep saying that they must have consumer, family member, and advocate input, yet I see no penalties for if they don't. And how are YOU going to know this anyway?	M
After BRAA finishes setting up its new private, nonprofit agency to handle mental health and substance abuse services, they will have even LESS incentive to encourage other providers to join the system. Don't you know what a power monger is? A few years ago, a bunch of psychiatrists and therapists got together and put together a plan for each of them to donate hours to treatment services for the indigent and poverty-stricken consumers in our area. The finalized plan was given to BRAA to carry out. It NEVER did. The project just fell by the way. This is what I've heard from at least three people. Talk with Thompson about it. BRAA hates to send anyone to training of any sort. Thompson has stated more than once that it's a waste of time and money.	M
I can't stress enough that there must be some sort of penalty (most useful would be a financial one, I think, that directly involves the administrative staff) in order to force LMEs to even HAVE a CFAC, let alone use it, give info to it, listen to it, etc.	M
You say on Page 1, "Turf protection will not be allowed." At the same time, you have already allowed Blue Ridge Area Authority (BRAA) to set up a private, nonprofit entity to "hold" all the land and buildings which it "owns" without recompense to the State of NC, the four counties involved, the City of Asheville, various federal programs, and all the private individuals and organizations which actually PAID for all that land and those buildings. You have known about this for over a year now. If that isn't "turf protection", then I don't know what is! Plus it is terribly unfair to the taxpayers and other donors to BRAA.	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
IMPLEMENTATION/ STATE & LOCAL BUSINESS PLAN	
As I write this, definite plans are underway to privatize the mental health and substance abuse programs and services which BRAA has always provided as a public entity. There was even a BLIND vote taken at the last BRAA Board Meeting to permit them to set up yet another private, nonprofit entity to provide the aforementioned services. This vote was taken without anyone being allowed to see the plan on paper and with very little verbal explanation of the plan. If you don't call that "turf protection" then I think those words have no meaning for you because it's the same "good old boys" system and personnel which will be employed at the new nonprofit entity as at BRAA--only the specific names change in order to cover their rear ends. They have enough people, power, and money to do that, you know. Larry Thompson (director of BRAA) outright admitted to subverting the new system at the Advisory Council for Adults with Mental Illness meeting last month. And didn't even have the decency to be ashamed or embarrassed by it.	M
These two moves by BRAA will leave no public oversight for our ONLY mental health and substance abuse system for poor people for four counties--maybe more than that since BRAA is talking about expanding into neighboring counties. BRAA already refuses to listen and act upon the suggestions of its Advisory Council and Client Rights Subcommittees as well as not giving them access to pertinent information in a timely manner (and sometimes, not at all).	M
Of course, BRAA also states that they will be the LME for this area. One of the LME's jobs is to oversee any and all private, nonprofit agencies providing services in the area. So we're back to the old fox in the chicken coop thing. This same "good old boys network" is going to run the LME AND the two private, nonprofit agencies for mental health? Am I the ONLY one who sees something substantially, perhaps dangerously, wrong with this picture? No conflict of interest at all. Uh huh	H
BRAA hasn't seen fit to include us in planning under the new system--so much for "meaningful input." BTW, Larry Thompson HATES to send ANY of his people for training as he says it wastes time, money and energy.	M
BRAA covers four counties--three of them rural. The rural counties are constantly "shafted" as far as BRAA services are concerned. This is a ridiculous use of resources when you consider that Buncombe County is the largest and richest of the four counties by far as well as having far greater "outside" resources. Therefore, Buncombe County doesn't have as much need for our public mental health system while the rural counties have nothing else to count on.	M
How on earth can the area programs justify an administrative overhead of 11% when the entire state's administrative budget is only 1%? I think there's something seriously WRONG here. Eleven percent is exactly half of what is spent on adult mental health! BAD wrong.	L
In BRAA's area, the county commissioners won't decide a damned thing unless Larry Thompson and Dan Gerber TELL them what to do. BRAA has not worked with any community partners to develop their local business plan as an LME. Once again, I don't want the same group of cronies at the LME to be overseeing the new private, nonprofit entity for mental health and substance abuse services.	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
IMPLEMENTATION/ STATE & LOCAL BUSINESS PLAN	
Thompson has been repeatedly asked in Advisory Councils and Subcommittees how he will handle referrals to other agencies and the recruitment and process training of new agencies to meet local needs. He has refused to answer in any substantial way. The people of THIS community would really like to SEE the local business plan, even if they refuse to let us participate in putting it together.	L
Once again, I'd love to see our local business plan... Sigh! How can I comment on how suitable our transition plans are when I haven't even seen them?	L
If each LME is supposed to build community capacity to provide adequate services to target populations, how can this be done when the LME refuses to do mental health and substance abuse services (such as BRAA is saying)? Obviously, this has not been stressed enough to the potential LMEs as Thompson said at the Advisory Council meeting last month that LMEs will no longer be ALLOWED to provide mental health and substance abuse services. This was not MY interpretation of reading this document. Rather, I think that he just doesn't want to do the appropriate paperwork and definitely does NOT want any oversight at all, if he can get away with it.	L
Another way to handle transportation issues in rural areas would be for the LMEs to provide a regularly-scheduled bus or van to transport clients to the nearest available place with appropriate services. Another idea for this problem is to work with the rural community to build at least a simple level of public transportation to a larger community where services ARE available (for instance, from Yancey County to Buncombe County).	L
Hooray for the "recovery-oriented" model for work, school, activity and leisure programs. I think that the annual progress report on addressing disparities in the MHDDSAS system should be widely publicized. In fact, you could use the publicizing of this report as a way to do more outreach through all forms of media. Copies of this report might well be distributed in such places as Social Security Offices, Food Stamp Offices, doctors' offices, clinics, emergency rooms, etc. to publicly acknowledge the problem and show that we are trying to address it.	L
I really think (and it was also the consensus of the consumer working group on our conference call) that the Consumer and Family Advisory Committees should be able to report, not only to the LMEs, but directly to the State as well since many problems are closely tied to, if not caused by, the LMEs themselves. Also, these CFACs should not be appointed by the LMEs or county commissioners as that is a conflict of interest. There should be widespread public calls for volunteers for the CFACs and the members should be chosen by all the consumers and family members who answer that call (should there be too many who answer the call for the committees). These committees should also be given all information necessary to do their jobs in an effective and timely fashion (which is not the case currently with these committees and councils at BRAA). Clear protocols for whom to contact at the State level should be available to these committees AND all consumers and family members who request them.	L
LOVE the report cards! The report cards are really great if you can get the info to fill them out properly.	L
How are we going to manage a 50% reduction in the population of our institutions by moving these people into our community, when we currently don't even have enough money to serve the people who are already in our communities? (17)	H

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
IMPLEMENTATION/ STATE & LOCAL BUSINESS PLAN	
Are there coordination agreements with different agencies (DSS, Health Departments, etc.) that will facilitate "no wrong door" for access to mental health, developmental disability and substance abuse services? Formal agreement on coordination at the Division level needs to precede coordination efforts at the local level.	L
How will consumers who are currently being served by Area Programs be protected from harm and assured proper continuity of care and other rights protections if Area Programs are compelled to divest services?	H
How will providers who are currently working for Area Programs be supported to facilitate continuity of employment in order to assure proper continuity of care and other rights protections for persons served if Area Programs are compelled to divest services?	L
The cost shifting that is an obvious part of the State Plan constitutes yet another unfunded mandate, which is occurring at a time when the State is already holding back substantial funding from the counties. (7)	H
How will provider rates be established?	L
Monitoring concerns: Who will do this, and based on which standards? This is essential! (5)	H
As we look at accountability and outcome measures, what will we consider a statistically significant success rate? And by whose desired outcomes will we measure success?	
There is critical need for a safety net to ensure that staff who are dismissed from one facility as a result of abuse charges are not allowed to go directly to another facility and be hired to work with yet another vulnerable group of consumers. I recognize that there is a registry of individuals who have been convicted, but this registry does not include those whose trial is pending for many months while waiting for a court date. If an individual charged with abuse/neglect, or even more serious charges, is determined by a judge in a probable cause hearing to be appropriately charged and faces superior court proceedings, that person should not be allowed to continue to work in a different location, same kind of work. This is happening probably far more than anyone knows.	L
With regard to the implementation of the state plan for reform in the delivery of mental health services, what mechanism is in place to ensure meaningful citizen review? I am specifically referring to the difference between token involvement of persons selected by the current regime and substantive involvement of advocates who are routinely closed out of the decision-making process. What mechanism will ensure that decision-making involves individuals and groups beyond the current regime and their token appointees? I am concerned about those Area Directors whose intent is to conduct business as usual, in which case the LME will be simply a continuation of the current board and administrative structure, just named something else. My fear is that nothing will change in Guilford County. The County Commissioners will look to the current area director to tell them what to do. She will happily oblige, develop her own version of a local plan with a very small, hand-picked advisory committee, and continue business as usual.	H

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
IMPLEMENTATION/ STATE & LOCAL BUSINESS PLAN	
Dear Sirs: To do away with the mental health centers will be a absolute disaster. I am a psychiatrist in the private sector. The waiting time in Hendersonville for a psychiatric appointment is at least 6 weeks. There is no way the private sector can or will absorbe the clients from the mental health centers. Many of these clients need case managers to render adequate care. You are trying to solve the states financial problems on the backs of the poor and mentally ill. You will end up with a absolute disaster. You wouldn't do this to cancer or to the OB patients. You will end up with no care for a group who have no one to plead their cause. I already work day and night to provide care for the elderly mentally ill and demented.	L
Three issues that continue to concern me are 1) the role of the case manager;2) the true cost of services;and the policy decisions to allow for porfit providers in the provider panel. The case manager is an integral part of the service delivery team and SHOLUD NOT BE ASSIGNED TO THE LME. The LME coordination role would focus on the provider panel with more of a <u>contract management focus to overall provider performance issue than day-to-day needs that a case manager would address</u> . The LME care coordinator would still need to understand specific slient needs uin relation to the provider's role. For example, If providers involved in a clients service delivery were working were working well together and clients needs were being met, then the LME involvement would be minimal. If service coordination problems arose, the LME involvement would increase. This would avoid loading costs at the LME level which is not intended to be the primary service provider.	M
It is imperative that LME functions be highly cost-efficient so that scare resources are preserved for client needs. The second concern is the true cost of the service system. A better system is not necessarily going to be cheaper as there are huge unmet needs. The legislature must have a honest picture of the cost of at least a "B+ level" system. The third issue is that the provider panel will allow providers who are "for profit". It is my understanding that the state of New YOrk does not allow for -profit providers for DD clients. I would ask the team to research thie issue to gain information about New York's decision. Profit going to top managers who never see a client is a real concern. One-on-one workers and residential workers for the most disabled are frequently underpaid and thinly supervised with resulting high turn-over and resulting weak service.	
This is a very serious issue for the future of MH/DD/SA services. I implore the team to give this matter close consideration and establish requirements to ensure that funds more adequately support direct care staff salary, training,and supervision. (This is not an issue for licensed therapist). Thank you for the opportunity for input.	
There are two separate but related issues currently impacting our service system: 1) the state budget crisis and 2) implementation of system reform. The state budget: For numerous reasons, the state is currently facing its worst fiscal crisis in decades.	M

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
IMPLEMENTATION/ STATE & LOCAL BUSINESS PLAN	
<p>\$160 million is needed just to meet life and safety requirments at John Umstead and Dorothea Dix, but this will not address the larger structural and design problems. The Secretary is committed to building a state-of-th-art treatment facility and will focus renovation and repair funds toward Broughton and Cherry Hospitals to substantially improve those facilities. Consolidation of the facilities will reduce both the workforce and hospital beds. The Secretary stated that over the transition period the Department would work with employees to find jobs either at the new facility, other state facilities, or outside of state government. The reduction in hospital beds is in line with the reduction proposed in the state plan. I raised the issue that this would not be successful and couldn't be done without the development of community services. The Secretary stated emphatically that no one would be moved from a hospital unless a service was developed and available in the community. She is working with the legislative leader to develop community services.</p>	H
<p>The Governor, who is required to maintain a balanced state budget, has taken action to reduce state spending. For the current fiscal year (ending 6/30/02), \$46.7 million has been withheld from the MH/DD/SA system inculding up to \$20 million from community programs. In addition \$37.5 million was taken from the MH/DD/SA trust fund. The Governor also has reduced funds to the counties and in response some county governments are reducing their funding contribution to numerous services, including mental health services. The combination of substantial state and county reductions so late in the fiscal year could have dramatic and long standing effects on many area programs and on community services. NAMI North Carolina along with other representativtes from Coalition 2001are scheduled to meet with Governor Easley and his staff early in April to urge that cuts to mental health services be spared.</p>	H
<p>The Governor has instructed state agencies to identify between 7-15% of their budgets for cuts. For the Division of MH/DD/SA that amounts to between \$40-87.1 million. Since administrative funds and funds that would have initiated new services already have been taken, additional cuts would come primarily from existiong services. In addition, the state will be implementing policies to reduce a Medicaid budget that is expected to be \$500 million over budget nest year. Options being considered are reducing payment to providers, limiting services provided and reucing the number of people eligible for Medicaid. All of these options will impact ability to offer and receive services. While cuts are one way to balance the state budget, the state also could raise additional revenues to cover the shortfall, thereby saving services.</p>	H
<p>It is critical that in contacts with the governor and ledislators, we urge them to consider options to raise revenues and that, in this election year, we will suport them in taking this courageous and necessary action. Reform Efforts: The implementation of reform efforts is often mixed up with the effects of the budget situation. Reform is often blamed for reductions in services that are taking place. Service reductions are NOT the result of reform efforts. In fact, implementation of reform at the local level will not even begin until next year. Conversely, the budget crisis and resulting service cuts will impact reform efforts. Reform was based on the need to expand community services in order to decrease the reliance on costly inpatient care. But without funding, and with a potential reduction of services, it will be very difficult for this to occur.</p>	H

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
IMPLEMENTATION/ STATE & LOCAL BUSINESS PLAN	
<p>NAMI North Carolina has heard many concerns regarding the state reform plan and it's implementation. On March 14th, 2002 NAMI North Carolina President Ken Farrington, Executive Director Kay Flaminio, and I met with Division of MH/DD/SA Director Dr. Rich Visingardi. Attached is a letter sent by NAMI North Carolina prior to that meeting as well as Dr. Visingardi's response. We will continue to work on concerns surrounding the state plan. However, the state is committed to proceed with reform efforts and NAMI North Carolina is obligated to help our members understand and participate in the process that is being initiated. The state has made some modifications to the implementation timeframe. Rather than proceeding statewide, implementation will be in phases. Programs wishing to be in the first phase of implementation had until March 18th to declare their intent. Eleven programs have officially requested to be in the first phase. These programs are listed in Dr. Visingardi's letter.</p>	
<p>By October 1st, all counties/area programs must declare whether they intend to offer mental health services through county government or through an area program. By January 1st, 2003, all counties/area programs must submit designated sections of their local business plan as outlined in the state plan. The remaining sections of the local business plans must be submitted by April 2003. Given these timeframes, county/area programs should be establishing citizen advisory committees to guid the development of their local plans. NAMI North Carolina members should be active paticipans in the training opportunitites across the state with a particular emphasis on those communities that will be in the first phase. The first training oppotunity is a workshop on the local business plan that will be offered at the spring conference. Dr. Visingardi also will make a presentation at the conference. I urge you and your members to attend.</p>	
<p>State Hospitals: Tuesday the Secretary of DHHS announced a plan to close Dorothea Dix and John Umstead Hospitals and build a new 432-bed facility. Despite news reports, the site of the new \$98 million facility has not been chosen. The transition will take place over 4-5 years/ The Secretary's plan was in response to a legislative request that she develop plans for a new regional psychiatric facility and draws on recommendations from numerous studies that previously have been done on the state psychiatric facilities. The new building will be financed through "Certificates of Participation," which are similar to bonds, and is a financing mechanism that has been used to build several prisons in the state. I attended a meeting with the Secretary the day after the plan was announced. She is appalled at the condition of the state facilities. She recognized that the present budget crisis created challenges and difficluties, but strongly believed that there greater negative consequences if system reform efforts did not move forward.</p>	
<p>This is a long letter with a lot of information it is critical for you to have to understand what is occurring for the mental health system in North Carolina. Again, I implore you, as leaders in our organization, to share this information with your members. NAMI North Carolina is working to respond to the diverse needs and concerns of our members across the state. Be assured that we are working on your behalf through these often difficult, confusing, and tumultuous times. As we have additional information we will communicate it to you. Please do not hesitate to contact me if you have any questions. Now, more than ever, we need to stick together, work together, and be united.</p>	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
IMPLEMENTATION/ STATE & LOCAL BUSINESS PLAN	
Policy Position(or strategy): We supports the intent of HB381 regarding the LME role in provider monitoring. The requirement of an LME to recruit, develop and assure a high quality service network requires the necessity to monitor providers at a local level for rules and standards related to quality of care, patient safety and rights, and other nonphysical plant rules. The Local Plan Work Group of the Secretary's Advisory Committee (comprised of county managers, county attorneys, and area directors) also resolved that local monitoring, exclusive of physical plant regulators, are the responsibility of the local authority. The bill requires that the LME be responsible for the development and assurances of an overall quality network. This requirement must be built on real authority (and leverage) to carry out this mission at the local level.	M
Therefore, bridge funding will continue to be an issue with the current status of no new dollars, the reality of community-based services may be difficult to achieve. The services that span the continuum of care are absolutely necessary to ethically and competently serve clients. There must be access to residential services, inpatient stabilization services, partial hospitalization/day treatment services and outpatient services. Attempting to provide mental health services in the community is best practice. However, it will be harmful to consumers if services are not adequate and funding is not available to provide efficient and effective services.	H
We oppose the development of any Area Program or Local Management Entity organizations founded for the purpose of continuation of the provision of direct services. Finally, we endorse the principles clearly established in the state plan calling for the separation of the management and delivery of services. The creation or expansion of any AP/LME development, management, holding, or similar organizations, such as foundations involved in service provisions, will be seen as unfair directly subsidized competition to the private provider community.	L
Promote client-centered practices by providing treatment in the most therapeutic and least restrictive environment. Pursuant to the Olmstead decision, we believe that consumers should receive care in the least restrictive and most beneficial environment.	H
In addition, practitioners may be forced to take on administrative tasks and consequently limit the time they have actual consumer contact. Many of the administrative duties (e.g., Medicaid billing, reimbursement and obtaining services for clients through Value Options) associated with changes in the provision of local mental health services may fall on the practitioners and not on the LME's. Overhead will increase for existing agencies and will be higher than the current market allows for those that are being formed. Again community based services are most appropriate but for the Plan to be truly realized, the financial support must be in place. As a result of the shift in the provision of mental health services at the community level, the provider has increased responsibility to assure that the consumer receives appropriate and necessary services. There is the potential for increased liability for the provider should the consumer not receive these services.	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
IMPLEMENTATION/ STATE & LOCAL BUSINESS PLAN	
We appreciate the opportunity to provide feedback to the draft State Mental Health plan. We are eager to participate in the process and provide input that can be of value. We support the North Carolina Council of Community Programs' position on the State Plan that calls for modifications in the plan that was submitted to the Joint Legislative Oversight Committee in December 2001. We support the call for analysis of the fiscal impact of the proposed changes to the system, for cost modeling, and for a pilot phase of these changes, in order to gauge the true impact of the changes on the system of care on consumers, and on quality delivery of care.	
The Council continues to have concerns and questions that require attention outside of the body of the plan itself. First, the order of priority for implementation of the plan needs state level direction. It is critical that DHHS provides some direction and expectation as to the sequential order of the change process. The State Plan is all encompassing in its reform effort and some prioritization is needed as to the relevant order of these change process. For example, it would seem logical that area programs, in their transition to LME functions, would address service gaps first (i.e., building of community capacity), then reintegration of institutionalized clients, then expansion of existing services/privatizing of public services. However, without some expectations from the DHHS in this regard, it is unclear whether LME's are expected to "do it all" at once, or whether a stepwise plan over the 1st three years, based on state level objectives is acceptable.	L
Second, and coupled with the above issue, the area programs need clear understanding of the concept of provider network development. What are the definitions of willing and qualified, reasonable effort, competition, choice, demand/access and how do they impact the strategic planning and action steps for provider network development and expansion. Third, the information regarding the administrative functions and core and targeted services will be funded is critical to any business planning process. The targeted populations need further specificity and refinement, coupled with clear statewide utilization management guidelines before any clarify regarding how far and deep the state dollars will spread. Without this information, the business planning process is superficial only. Finally, it is critical that DHHS engage and assist area programs and counties in addressing transitional issues for both nontargeted populations currently being served as well as direct service employees who will transition in their employment status.	L
Area programs retain approximately 5000 staff across the state. These transition issues will serve as barriers to successful implementation of the state Plan without careful, thoughtful deliberation by DHHS and the General Assembly.	L
Our work group has had extensive discussion about the rules process. Through this discussion, we have discussed the way in which it is determined that any issue may be resolved by developing a rule, a statute or a State policy. It does not seem that there is a consistent process by which this determination is made. The work group would like to encourage the Division to develop a process or protocol to determine when it is appropriate to develop a new rule or State policy or pursue a statutory change in order to resolve an issue. An example that has recently arisen is related to the competency-based system that is being developed. It was not initially clear as to whether this would be processed as a rule or as a State policy.	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
IMPLEMENTATION/ STATE & LOCAL BUSINESS PLAN	
We appreciate that the Division has now clarified that the full competencies will not be in rule, but it would be most useful in this instance and in the many others that will undoubtedly occur as we implement the State Plan if there was a consistent protocol or process that is used to determined the appropriate course of action. This type of clarification would be very beneficial to statewide and local organizations that advocate for the public MH/DD/SA system so that we can better understand the opportunities available to us for input. We would welcome the opportunity to work with you and your staff further on developing this concept. Thank you for considering our proposal.	L
It takes so long to get something from the county that we go ahead and pay in order to get what we need. Medicaid must pay for organized peer support and other similar services because this is what MI folks need. This should be part of their medically necessary treatment. Medicaid Waivers-deinitely needs expanding to get federal leverage and dollars. There is little mention in the plan about how to fund the residential supports individuals will need in the community as the MR Centers are reduced. It can not be done with the current Waiver. It (State Plan) is going to push apart things that are together (like) housing, coutinuing care. Everything is now run from the area program. The people in my city are scared. Everybody is afraid that local funds will be taken away. Medication keeps you out of the hospital. People with mental retardation get about \$200-\$300 a month CAP. But people with mental illness only get \$85. It is unfair that people with MR can earn more money than people with mental illness can.	L
We would like the county model. We don't have a say on the board of directors.	L
Utilization Management.Utilization Review: According to the State Plan, UM will occur at the state level. It is more appropriate for UM to occur as close to the individual supports as possible, especially in more complicated cases.	L
Although the Secretary accepted recommendations from the state consumer advisory group that there be a "sign-off" on the local family/consumer advisory group, there is a great deal of confusion around how is actually supposed to work. We believe this family/consumer advisory group should be a committee of a larger planning group comprised of a broader range community representatives. This would ensure that family/consumer input is part of all deliberations and allow for consistency in information and communication.	
(We), by a vote of the Board of Directors, hereby take a formal position strongly endorsing: Enhancing capacity in the community to meet the needs of people with DD,MH, and SA support needs via a private provider network; The depopulation of current institutions via the utilization of the Area Program?LME RFP process; Reasonable timetables for development; Adequate funding for the serfices required on a person-by-person basis, and; The waiver of unnecessarily hindering rules to accomplish the above to the benefit of the consumers and families that will be supported. We must however, oppose the development of any Area Program or Local Management Entity organizations founded for the purpose of continuation of the provision of direct services. Finally, we endorse the principles clearly established in the state plan calling for the separation of the management and delivery of services. The creation of expansion of any AP/LME development, management, holding, or similar organization, such as foundations involved in services provision, will be seen as unfair directly subsidized competition to the private provider community.	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
IMPLEMENTATION/ STATE & LOCAL BUSINESS PLAN	
<p>Overall the requirements for the Local Business Plan, as outlined in the State Plan go far beyond the requirements in the Reform Bill. The submission requirements are cumbersome and are based on description vs.outcomes. The Secretary must also develop the criteria for approval of area programs to provide services. Suggested change: (pg 11) The first sentence in the second paragraph should read: County/Area programs may provide direct services to target populations as approved by the Secretary, through approval of the Local Business Plan. Approval may be granted (delete for a temporary period) based on..." Delete last sentence of that paragraph. The issues listed in last sentence, pre-existing obligations, unavailability of qualified providers, consumer choice and fair competition, on page 11 should be reflected in required elements table on following page.</p>	
<p>(pg 12) The language in Required Element #2 exceeds legislative intent. Suggested Change:"The LME must include a plan describing how it will attract and work with private providers to enhance service provision within the Area/County. The corresponding approval criteria is not consistent with all elements - approval criteria should not be based on a full transition within 3 years, it should be based on the identification of clear transition goals and realistic timeframes for increasing consumer access to privately provided services.</p>	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
CORE SERVICES/ SERVICE GAPS	
How can we do efficient prevention and early intervention that will keep people out of the hospitals if all of our resources are put into serving people in crisis?	H
At a recent conference, author Kathy Cronkite mentioned the importance of screening individuals for both mental illness and substance abuse since substance abuse is often present in individuals with mental illness.	L
What type of preventative and early intervention services will be provided, and who will pay for these services if the State is only going to pay for crisis services and services to those who are already most severely impaired? (2) (MH & SA)	M
Although the State Plan talks about transportation, there is minimal public transportation in rural counties like Jones. How will additional transportation service be funded? Will it fall on the local county governments?	H
We need to increase community awareness of consumers' needs and capabilities, and their desire for community integration. Education	M
Family Education is needed. What kinds of education are we providing? (2)	
Is the money being spent on Substance Abuse education and prevention being spent effectively? In the schools, etc.	
Core and Target Services (pgs. 12 & 23) (We) are unclear what the legislative intent was concerning "service standards" and would like a clear definition. The Statute requires the State Plan to provide service standards yet they do not appear in the State Plan. Suggested change: Service standards must be defined and developed that will meet the needs of the staff and consumers. (We) are willing to work with the Division to develop service standards.	
Bed day allocations (pg 37) The Statute outlines as a core administrative function "the management of hospital/facilities bed days". While the State plan states they will develop a bed day allocation system, it (is) not detailed in the Plan. Management of bed days is a key function of management for core and targeted services, screening, assessment, and uniform portal -- all management fuctions of the LME. Suggested change: Best practice across the country is to allocate the resources that accompany the bed days to the LME. The Plan should read that the State will develop a system to allocate resources to the LME for the purchase of bed days from State facilities. These funds may be used to purchase bed days or develop community alternatives.	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
ACCESS	
Page 13 - The Uniform Portal is, I think, a good idea. It is my hope that it will also make it much easier for providers (large and small) to: access information about their clients to prevent duplication of services; make accurate and timely reports to all relevant statewide agencies AT ONE TIME; receive notice about changes to ALL statewide systems because you never can tell when you're going to need to refer someone out or someone will have a question you'd like to answer; greatly reduce the amount of actual "paperwork" involved by putting as much as possible on a statewide computer system so that they do not have to re-write everything for ten different agencies just to get paid for doing one service to one individual; actually SEE what feedback they've gotten from clients so that they can, if necessary, adjust standards and practices so that they are most beneficial to clients.	M
There is concern about the effectiveness of having a 1-800 number for screenings statewide. People want to feel some personal connection with the person who does the screening, and then there is the issue of the people who come in and out of the system over and over again. Local screeners will know the person already, whereas the 1-800 screener will never develop any relationship with the vast number of people they hear from.	
The 1-800 telephone number for service access will not be effective for meeting the service needs of this population. (5)	M
Availability of Services and Personnel in Rural Areas: As noted in our earlier feedback, this is not a new problem but our concerns continue that this could worsen with the State Plan. Simplify the Consumer/Client Rights/Ombudsman Process-We continue to recommend that areas of duplication be continued and processes be streamlined. We appreciate your time today and the opportunity to provide feedback on the State Plan.	H
Assuring Access to Quality Care: Before moving any patients from our institutions, quality community services should be in place. Psychologists have advanced training and expertise to make a major contribution in this regard. We would like to know what the Division is currently doing to ensure that best practice services are in place prior to further closing of hospital beds. Our interest would include knowing the Division's criteria for assessing successful implementation of community services (that would then lead to informed decisions to reduce hospital beds) and the specific quality improvement processes that are being used. Who is responsible, when, and where? Psychologists could play a key role in the QI process, and would welcome the opportunity to do so. the LOCUS/CALOCUS is being used to evaluate the services each hospitalized patient will need to be placed in the community. At this point, many of these services are unavailable.	H

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
ACCESS	
To focus in more depth on one population, there is already an effort on the part of the Division to move a large proportion of ICF level geropsychiatric patients out of the hospitals by June 30, 2002. These patients are highly compromised, having both mental and physical illness. They frequently exhibit behavioral symptoms that make their care a challenge. The only bridge money designated for these patients is \$20,000 for minor renovations at the Wilson Care Center and \$100,000 for Real Choice Case Information and Assistance. The only placements available are Wilson Care Center and local nursing homes. Although less expensive, moving patients to Wilson Care Center is not a real community placement, but rather is a move from one institution to another. Also, unless the patients are from that community, they will be farther from family members and supports than they were when hospitalized, creating logistical and emotional hardships.	
Local nursing and rest homes have numerous problems that make them a poor choice for the care of our patients. These include staffing shortages, high staff turnover, poor training in the care of persons with mental illness, and insufficient therapeutic treatment interventions designed for persons with psychiatric problems. There is also far less oversight in these facilities relative to rights issues, as compared to state-operated facilities. Specialized group homes and foster care have been successfully tried in others states should be considered as viable alternatives to nursing or rest home placement. Nursing and rest home staff need to be trained and given ongoing supervision in behavioral and psychosocial treatments if they are going to care for persons with such problems. It would be desirable to utilize the expertise of the professional staff at our state facilities as a training, program development, and clinical supervisory resource until community capacity can be fully established.	H
1). DD has more resources and rights are more exercised than with the MI consumer. 2). Housing and employment is too limited in terms of quality and availability. 3). Need more club houses and ones that are not restricted to members only. 4). The emergency/crisis Sections of the plan for DD are not spelled out, as they need to be. (For example, where will the Statewide Crisis # refer folks to?) 5). People with autism and their families are often in crisis and have nowhere to turn. 6). The deaf and blind need transportation as an option to get to VR or to go to school. 7). Communication resources for deaf MI consumers are drastically lacking. 8). Having a dual diagnosis is a Catch 22 situation and makes getting appropriate services even more difficult. 9). What will happen to the consumers who have no place to go to adequately meet their needs?	L
(This woman) is being treated for depression, but cannot afford to pay for both therapist and pay for her medication.	L
Developing sufficient housing options for people with disabilities is essential for the success of reform efforts. Planning for supported housing must be included in the local plan. While LME's may choose not to become housing developers, they must play an integral role in assessing, the need, encouraging and advocating for the development of housing for people with disabilities, and actively partnering with developers to provide support services.	H

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
ACCESS	
Uniform portal needs to be more clearly defined. Without clear standards and definitions we are fearful that uniform will be anything but uniform. The uniform portal/800 line utilization management must include services requested for individuals residing in adult care and nursing homes. At the present time the needs of these individuals and the services they require are often outside of the awareness and management of local programs. LME's cannot truly manage community services if adult care and nursing homes are outside of their authority.	L
I want to make sure that the project team is aware of an issue of critical importance from our system's perspective. The issue is the current practice of some children having to be removed from their families and enter foster care in order to get their mental health needs met. We believe that this is an injustice to families, a misuse of foster care, and an impediment to the provision of effective support services for families and children. This is primarily a financial management and "placement culture" issue, as a county DSS can provide the same services to a family on a voluntary basis that they provide when children enter foster care, with the exception of payment for the room and board costs of a placement. Our system strongly endorses the concept of Child and Family Teams that work collaboratively with families to develop and implement plans to meet their needs without requiring an unnecessary out-of-home placement.	L
We would like to see a requirement that the local business plans must include an assurance that children will not be required to enter the foster care system to access needed mental health services, as well as a requirement that each LME must include information on the number of children diverted from foster care in whatever periodic, outcome-oriented reports they will be providing to the Division/Department. I will be glad to provide additional information about this issue if it will be helpful to you. Thank you for your consideration of this recommendation.	
800# (pg. 13) Several problems have been identified with the Statewide contactor. First the Plan states that the 800# provides referrals and authorizations to providers on a rotating basis which appears to be in conflict with the concept of person centered planning and local authority. Second, the relationship between the 800# and the Uniform Portal is unclear. Third, the goal of the Reform Bill was to strengthen local accountability, the Statewide 800# seems to take that away and therefore is in conflict with legislative intent. Suggested Change: The 800# should be an information and referral number only, refer callers to their LME or to the designated point of contact for the catchment area.	
Uniform Portal: The State Plan description of Uniform Portal is vague and doesn't offer any suggestions as to how this will be operationalized. Suggested change: The LME shall provide for a uniform portal of entry and exit policy for services for individuals with mh/dd/sa as demonstrated in the local business plan and applied across all disabilities and all core services. All public and private mh/dd/sa providers that provide services that are publicly funded shall be subject to the uniform portal process.	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
QUALITY MAMAGEMENT PLAN/ LOCAL BUSINESS PLAN	
What requirements will providers be required to follow?	H
The system needs to be more concerned with quality than quantity, and to achieve/assure quality, monitoring visits should be unannounced. (1)	M
Page 4 - Once again, it's really nice that you expect the local Consumer and Family Advisory Committee (CFAC) to get info from clients and such in order to monitor providers; however, you'll have a hard time doing that with the same people in charge at BRAA and the new private, nonprofit agency they want to set up. They simply do not like oversight and will not listen to suggestions or anything else anyway. Plus, they stack these committees with brown-nosers who'll do anything to keep the director happy in the mistaken belief that their family members will get better treatment if they kiss his royal rear.	H
Good luck getting Thompson or anyone else at BRAA to allow consumers and family members access to the documentation which you outline under "System Quality Management Plan."	
My question is where are the teeth in the process to keep the charade from continuing. If the local plan is not submitted according to the prescribed criteria, what is the consequence? If a local plan is submitted but not approved, what is the consequence? If the citizen review process is short-circuited by a less than honest approach to the selection of appointees to the citizen review committee, where are the teeth in the plan?	
Caller from Raleigh: "In terms of the state getting information out to area boards, the mental health system has become such a political travesty that information doesn't get down to front line folks." He feels that the area boards have become too invested in their power, and don't want to give it up. They want change to be as limited as possible. He says Durham is especially bad and needs a state takeover.	H
While strongly supporting the need for consumer choice, the plan should provide for greater flexibility to allow LME's to provide mental health services and to provide them beyond the current three-year period. Some families and consumers have raised concerns that critical services, for example crisis response or ACT teams, may need to remain a public service of their communities to provide stability and consistency. They also are ongoing about the availability of qualified providers to provide services. At the same time the plan needs to be more specific about the requirements to demonstrate the necessary "firewall" between services and management to ensure there is not a conflict of interest.	H
A state-level process should be established to hear and resolve concerns about the state plan itself or about how a local planning process is proceeding. We believe it is in the best interest of the reform process to identify, respond to, and mediate concerns as they occur instead of having a situation where concerns are not addressed and become big problems. For example, there are some areas where consumers and families have felt that planning decisions are being made without their knowledge or input. A state process would allow for these concerns to be raised and mediated before a local business plan is submitted without stakeholder support.	M
There has been additional committee work on the role of the LME in monitoring facilities and services. This should be included/reflected in the local business plan requirements.	

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
TRAINING	
There is a critical need for better training of direct care staff who work with persons with severe and persistent mental illness. So many staff know so little about the characteristics and needs of people with mental illnesses. Although there is an attempt at staff training, the reality is that the training is too little, and does not contribute much to knowledge and understanding of the individuals being served. I think we need a system of staff training that is comprehensive enough to result in certification, and that certification should be required for employment of direct care staff. The current system of staff training is woefully inadequate. Our consumers have a right to receive care from qualified professionals, not just whoever happens to apply for the job and can fill the vacancy quickly.	H
I read with great interest the minutes of your competencies workgroup. I am currently employed as a Mental Health Program Manager with a contract provider serving the MH/DD. I am a master level licensed professional and I have served the mental health population for 10+ years. I appreciate your efforts to implement higher standards for Q's. Given that Q's are out in the fields, and are providing supervision to direct care providers, I think it is imperative that Q's have the minimum qualifications of a case manager. For Q's supervising direct care providers to the MI population, I recommend they have a minimum of a masters degree. We need qualified professionals in this field!	M
Staff: The Commission recommends that Actions be taken as soon as possible to advise the Governor and all professional education and training agencies in North Carolina, particularly the two- and four- year institutions of higher education, public and private about the MH plan and it's personnel needs and the actions be taken by the leadership DHHS and the Division of MH/DD/SAS to seek coordination and support from all levels of education in North Carolina in implementing the Plan. Similar steps should be taken, as well, with other state agencies outside DHHS, including the SDPI, the Department of Criminal Justice, the Department of Agriculture, and the other relevant agencies.	M
If there is any hope at all of making this "Community" project work, the quality and number of participating professionals must be greatly improved. How can this be done? These professionals must be highly qualified, highly respected by their peers and the community; unfortunately for our budget, highly paid. Small towns have little or no chance of acquiring such people. Your data showing numbers of employees employed at Dorothea Dix and Butner were a surprise to me. I have not visited either facility, but I have visited Cherry Hospital. While visiting Cherry, it was obvious that many of the employees are unskilled and untrained in many medical discipline. The quality of education of these people must be improved. With highly qualified people in communities or institutions, the expense is surely high.	M
Where do we get the money? Initially we must take a budgetary hit; however, in the longer term we will save considerable money by having a saner population, fewer crimes, fewer arrests and few prisons. Yes, this is difficult to sell, but we must offer higher quality mental health services to our citizens.	M
Stakeholder Involvement: Peers need to train each other and train professionals on how to relate and work better with consumers.	L

STATE PLAN FEEDBACK 2002

FeedBack	Frequency Hi/Med/Low
TRAINING	
We need training at the local level to become knowledgeable about how to involve the community re: legislature, budgets, State Plan, medical necessity, etc.	M